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Health Systems Agency:
A Primer

Ocular Manifestations of
Phycomycosis in a Diabetic
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et al.*

Pregnant Adolescent:
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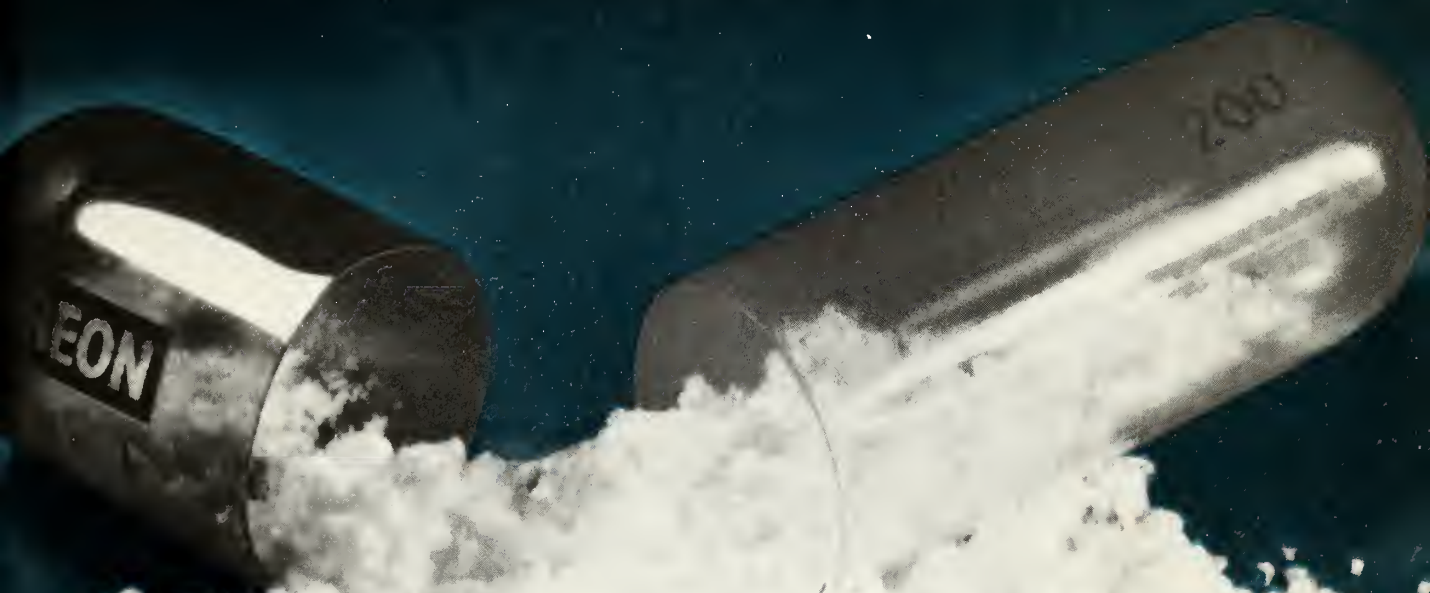
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tions as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

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Screening for Colorectal Cancer

The purpose of a screening program is the early detection of disease with the hope of eradicating it, if possible. Screening for cancer certainly should aim at the discovery of malignant disease while it is localized and curable.

How are we doing with cancer of the colon and rectum? Not very well, it seems, since the five-year survival rate for colorectal cancer has shown little improvement in the past 10 to 20 years. It appears that "earlier diagnosis of malignant lesions, wide resection of bowel mesentery with inclusion of contact organs when involved, and low operative mortality rates resulted in a 50 percent increase in the five-year survival rate for colorectal cancer between 1949 and 1960," however, "from 1960 to 1974 there has been essentially no improvement in the survival rate," which remains at 40 percent.¹

There can be little doubt that the stage of the cancer at the time of initial surgery is a prime determinant of the ultimate prognosis. One must assume also that earlier diagnosis and prompt surgical extirpation is the pathway to better prognosis.

What is the best (most cost-effective, sensitive, and specific) method for the detection of colorectal carcinoma? Is it routine sigmoidoscopy, or barium enema x-ray with selective use of colonoscopy? How about a careful screening history? Not at all—it's the Hemoccult[®] test that wins out.

A summary report of five large screening programs for colorectal cancer involving almost 10,000 patients indicated an early cancer detection rate five times the expected cancer rate through the use of Hemoccult[®].¹ This clearly outdistances routine sigmoidoscopy and barium enema x-ray. Furthermore, sigmoidoscopy is not free of morbidity or mortality; barium enema x-ray, like sigmoidoscopy, is not

pleasant and both are rather expensive.

Hemoccult[®] testing of stool does indeed detect cancer of the colon and rectum, and has been endorsed by the American Cancer Society "as a form of early cancer detection." This method is simple, inexpensive, sensitive, and esthetically acceptable. It has a relatively low incidence of false-positives even when the patient is not on a meat-free diet.

So, how do we improve the five-year survival from cancer of the colon and rectum? According to the experts, we do the following:^{1,2}

1. Use Hemoccult[®] testing of stool as a screening procedure on all patients over 40 years of age in routine office and clinic practice.
2. Perform the test twice a year.
3. Whenever practicable, patients should eat a meat-free, high-residue diet starting two days before and continuing through the test period.
4. Stool specimens for testing should be collected from three consecutive bowel movements.
5. Smears should be taken from two different sections of each stool, thus one makes six Hemoccult[®] tests as the screening procedure.
6. Where positive results are found, diagnostic follow-up procedures are indicated, including sigmoidoscopy, barium enema x-ray, and so on.
7. Refer patients with demonstrated colorectal cancer promptly for surgical intervention.

A.K.

¹Miller, SF: Colorectal cancer: Are the goals of early detection achieved? CA 27:338-343, 1977.

²Smith Kline Diagnostics: Hemoccult[®] slides and tape. Product instruction, 1977.

The Health Systems Agency (HSA)

In March 1978, the Executive Committee of the Board of Trustees of the Medical Society of New Jersey "implored all members to become knowledgeable and to participate in the public meetings of their local HSAs." If we physicians ignore this mandate and never learn that apathy is deadly, we will have to live with the bitter fruit of such heedlessness while others direct the conduct of our professional lives.

The further recommendations of the Executive Committee—all of which were approved by the Board—included the following:

- (a) That all county medical societies within each HSA

area should develop close liaison with one another in terms of disseminating information and working together toward influencing HSA Activities.

(b) That each county medical society should designate, at least, a staff or board of trustees' member whose sole function would be to review and comment to the county society on HSA activities.

(c) That each county medical society, when it believes its local HSA to be acting in conflict with the concept of good health care delivery, should formally notify, in writing, the Medical Society of New Jersey.

(d) That the Medical Society of New Jersey hire or designate a staff person to collate such reports, study their validity, and recommend appropriate action for consideration by MSNJ's Board of Trustees.

(e) That the Medical Society of New Jersey, where indicated, act as an advocate of the local county society before the State Health Planning Commission in those instances where conflicts have not been resolved at the local level.

Why should you participate in this grass-roots activity? How serious is HSA? Where did it come from? If you do not know, study the primer on HSA which begins in this issue (page 566). Get interested, and, if possible, get involved!

In brief, the Health Systems Agency concept is a further step forward in the socialization of the American health care system. One characteristic of government planning is that the planners rarely give up old programs. They tend to change their names and to add to them. Each addition also compounds the cost to the American taxpayer in order to support what the bureaucrats perceive to be the *ultimate* of plans. HSA is an outgrowth of a series of now-familiar ancestors—the Hill-Burton Act (funds for hospital construction), the Regional Medical Program (RMP) and the Comprehensive Health Planning Act (CHP). The basis in law for HSA is the National Health Planning and Resources Development Act of 1974 (P.L. 93-641). This act is divided into two sections: "National Health Planning and Development" and "Health Resources Development."

If all of these acronyms make you feel like a mosquito on the buttocks of an elephant rather than the "king of the hill," read on. The dollar value of all this planning and organization is nothing to sneeze at. There are or will be 204 HSAs in the United States. Each of these is funded by the federal government at the rate of fifty cents per capita, i.e., more than 100 million dollars per annum. As a specific example, the Central Jersey Health Planning Council, Inc., the HSA for Hunterdon, Somerset, Mercer, Middlesex, Monmouth, and Ocean Counties, has a staff of 22 employees, six planners, and a budget of one million dollars. The number of staff persons is based on the formula of one professional staff worker for every 100,000 citizens in the health service area.

*Brochure: Central Jersey Health Planning Council, Inc. "... for a healthier tomorrow."

Simply stated, these professionals are "planners" and "developers," whose disciplines include engineering, environmental health, statistics, social science, psychology, health planning, urban planning, hospital administration, education, financial management, and advertising and design. It is fascinating that not a single health planner on the staff is a *physician*!

Although the staff is broken down into units (Evaluation Unit, Plan Development Unit, Administration and Training Unit, and so on) they are not just paper shufflers. They are dealing with activities which will influence, and, to some extent, control your professional life. And, like all bureaucrats, they must have their own language and jargon, which is meant to "clarify." The following is an example of such "clarification":

"Health System Taxonomy"

"The term 'health system' is used in various ways. 'Hospital' and 'doctor' are symbols of the 'health system' most used in public and political language. The fact of the matter, however, is that numerous other terms are used to define the 'health system.' These other terms are such a mixture of words and context it is extremely difficult to relate one to another. Often, the result is confusion and misunderstanding. One of the first jobs of the HSA is to provide a comprehensive definition of the 'health system.' One way this is done is by developing a taxonomy. In practical terms, a taxonomy is a systematic way of arranging groups or categories of health system components so that the relationships can be clearly described and the impact/dependence of one service on another can be ascertained. A taxonomy is not to be confused with the health system. Rather, it is a technical device for planning a health system. Perhaps more important, it is most useful in establishing a common language for consumer and provider communication."

Do you get it? If not, ask your HSA what it means.

Who controls the HSA? The governing body is the Board of Directors, which is composed of a total membership of 49. The Central Jersey HSA, as of November, 1977, included *two medical doctors, one chiropractor, and one optometrist*.

Can we physicians bury our heads deeper in the sand while the "planners" walk away with the ballgame? Certainly, and we'll have no one to blame but ourselves for the unholy mess heaped upon us.

Let this **not** happen! Every physician and every county medical society must be interested, knowledgeable, and participative.

A.K.

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Meeting Gives Standing
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"If we fail to use it," he declared
to the solemn final meeting of the
delegates, 'we shall betray all of
those who have died in order that
we might meet here in freedom and
safety to create it.'

"If we seek to use it selfishly—for
the advantage of any one nation or
any small group of nations—we
shall be equally guilty of that be-
trayal."

Fervent Interpolation

The President, speaking in the
auditorium of the War Memorial
Opera House, built in memory of
sons of the Golden Gate city who
gave their lives in the first World
War, in which he himself served,
seemed to give unconscious expres-
sion to the solemn feeling of the
occasion when, at the outset of his
speech, he interpolated the words,
half a hope, half a prayer:

"Oh, what a great day this can
be in history!"

Just before the plenary session
the President accompanied the

Social Security Bill Is Signed; Gives Pensions to Aged, Jobl

Roosevelt Approves Message Intended to Benefit 30,000
Persons When States Adopt Cooperating Laws—He Calls
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Amendment to Constitution
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WASHINGTON, March 10,
1971—The Senate approved
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The Social Security Bill, pro-
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insurance and old age pen-
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20,000,000 persons, became
day when it was signed by
dent Roosevelt in the pres-
those chiefly responsible for
ting it through Congress.

Mr. Roosevelt called it
"the cornerstone of my
which is being built
meets complete
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the Draft Ends Now

WASHINGTON, Jan. 27,
1973—"With the signing of
the peace agreement in
Paris today, and after re-
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Secretary of the Army that



PATIENT PACKAGE INSERTS: A CONCEPT WHOSE TIME HAS COME?

The consumer's right to know is an irreversible and desirable trend of the Seventies. It extends, and properly, to a patient's right to know more about his or her prescription medications. One way, gaining favor, is through patient package inserts. Wisely-prepared and properly distributed when medically indicated, they could markedly improve patient knowledge and drug therapy—laudable goals by anyone's standards.

The PMA endorses these goals and will work with government, the health professions and consumers to achieve them.

The Advantages

The concept holds promise of benefits: better patient understanding of the product prescribed, better adherence to the treatment plan, and more awareness of possible side reactions.

Every doctor has had patients who fail to finish antibiotic regimens because they feel better. Some patients assume that if one tranquilizer or analgesic is good, two may be twice as good. Still others fail to report dizziness while on antihypertensive therapy—and so on.

Problems like these might arise less often if the patient received written information in addition to verbal instructions. Some studies suggest that patients are more receptive to such materials, and they more often understand the verbal instructions and follow them, when inserts are used.

The Disadvantages

There are also some potential problems. Obviously, the inserts must be clearly phrased, without extraneous or complex detail. How much information

is enough? How can it be kept current? Should all patients receive the same information? Should inserts be included with all drugs? Should only potential problems be listed or are patients better off with a "fair balance" presentation that describes usefulness as well as drawbacks?

These and similar questions require answers, since model inserts have yet to be properly developed and tested. Despite the need for these studies, the FDA is proceeding prematurely with inserts on selected products. We think the Congress is the only place where the matter can be given the proper legal status and direction, particularly since it represents a conceptual change in the legal, medical and social framework of the nation's prescription drug information system.

The Solution

The PMA believes that carefully-devised pilot studies of various kinds of inserts are needed. They should be developed and implemented with full participation by doctors, pharmacists, consumers, communications experts and the drug industry. Such studies will provide reliable pathways to follow, so that inserts will be useful aids to medical practice.

And particularly we think that you should be closely involved in this debate and in these studies and decisions. Otherwise, people with less experience and qualifications may control the purposes, content and use of a tool with considerable promise for improved patient care. It could make a difference in your practice tomorrow, and more importantly, in the health of your patients.

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Ocular Manifestations of Phycomycosis in a Diabetic

BARRY A. MALTZMAN, M.D., DOMINIC A. MAURIELLO, M.D., THEODORE PEARLMAN, M.D., NIKKI GO, M.D., Jersey City

A 34-year-old woman developed diabetic ketoacidosis and orbital cellulitis. Biopsy of nasal mucosal tissue revealed pseudoseptate hyphae of mucormycosis. One eye developed edema of the lid, purulent chemotic conjunctivitis, a fixed pupil in mid-position, impaired motility and permanent hand-motion vision. The phycomycosis was cured after 2105 mgm. of amphotericin B and ethmoidectomy and sinusotomy. The prognosis in ocular phycomycosis depends on elimination of the diabetic ketoacidosis, demonstration of the fungus, prompt treatment with amphotericin B, and aggressive surgical debridement.

Rhinocerebral phycomycosis is an uncommon disorder, but it must be suspected in a diabetic with ketoacidosis and orbital cellulitis. Biopsy diagnosis is important and early treatment with amphotericin B plus surgery is crucial. This case in a diabetic with the classical clinical features of ketoacidosis and eye involvement is presented in detail with a discussion of the mycopathology.

CASE REPORT

On July 11, 1976, a 34-year-old female came to the emergency room of the Jersey City Medical Center complaining of shortness of breath, dysuria, urinary frequency, nausea, and vomiting for four hours. The left eye had been moderately painful for two days and she noted numbness of the left side of the face. She had had diabetes for one year and apparently was well controlled on chlorpropamide, 250 mg. daily, and phenformin, 50 mg. twice daily. Two years previously she was cured of left maxillary sinusitis with antibiotics and drainage. Past history and family history were negative.

Physical examination revealed a well-nourished, well-developed female in moderate distress. The oral temperature was 98°F., the blood pressure was 150/90 mm/Hg; the respirations were slow and deep at 16/min. The head was normocephalic, but the eyes were somewhat sunken. There was neither redness nor swelling; the pupils reacted well to light and the fundi and the extraocular motions were normal.

The ears, nose, and throat were said to be normal. The neck was supple without venous distension or masses; the carotid pulses were normal. The lungs, heart, abdomen, extremities, and neurological examination all were normal. The skin and mucous membranes were dry. Although she was slightly lethargic, she was easily aroused and was oriented.

Initial laboratory findings revealed a blood glucose of 520 mg/dl, with a large amount of serum acetone; arterial pH was 6.98. Hemoglobin was 18.6 Gm., hematocrit was 54 percent and the white blood cell count was 25,300 with 67 percent polymorphonuclears, 5 percent stabs, and 28 percent lymphocytes. Radiologic studies showed marked clouding of the maxillary and ethmoid sinuses.

Following treatment the ketoacidosis was controlled within eight hours of arrival at the hospital. Because of crepitant rales at the right base, which were heard several hours after admission, sodium cephalothin was administered intravenously in a dose of one gram every six hours. Later that evening, redness and swelling of the left eyelids developed. On the morning of the second hospital day, the lid swelling was much worse. (Figure 1) In addition, the lids were hot, but not very tender to touch. The conjunctiva was chemotic and beefy red with a yellow purulent discharge. Specialists in

*From the Department of Ophthalmology, Jersey City Medical Center, Jersey City, New Jersey, and New Jersey Medical School, CMDNJ, Newark. Dr. Maltzman is Director, Eye Clinic, Jersey City Medical Center, 30 Baldwin Avenue, Jersey City 07304. Correspondence may be addressed to him there.



Figure 1—Left eye on admission, with cellulitis and chemotic conjunctiva.

infectious disease and in ophthalmology were called in consultation. Ophthalmic examination revealed uncorrected vision in the right eye of 20/20, and hand motions in the left. The left eye exhibited marked swelling of the lids, with a purulent discharge from a chemotic conjunctiva. The cornea and anterior chamber were clear. The left pupil was round and fixed in the mid-dilated position to both light and accommodation by both direct and consensual examination. Sensation to pain and light touch was impaired in the skin of the supraorbital and infraorbital regions. A blink reflex was not elicited. Motility was severely impaired, with only a small amount of adduction present. Forced duction tests were positive. The fundus was normal with no venous engorgement. The right eye was normal.

After control of ketoacidosis, the state of consciousness had improved. An oral temperature at this time was 103° F. There was a serosanguinous discharge from the left nostril. These findings were interpreted as representing an orbital cellulitis, secondary to underlying sinusitis, and orbital apex syndrome. In addition to the bacterial etiologies, mucormycosis was strongly suspected. Chloramphenicol, 500 mg, and nafcillin, one gram, were administered intravenously every four hours in place of cephalothin on day two. On hospital day three, the vision had improved slightly to finger counting at two feet; a small increase in adduction was noted but the swelling was unchanged. An otorhinologist examined the patient and found black crusts on the middle and inferior turbinates resembling dried blood. A biopsy was made and reported the following day as rhinomucormycosis, characterized by broad, non-septate hyphae, staining very well with H&E and silver stain. (Figure 2) Several sections revealed the characteristic invasion of the arterial intima.

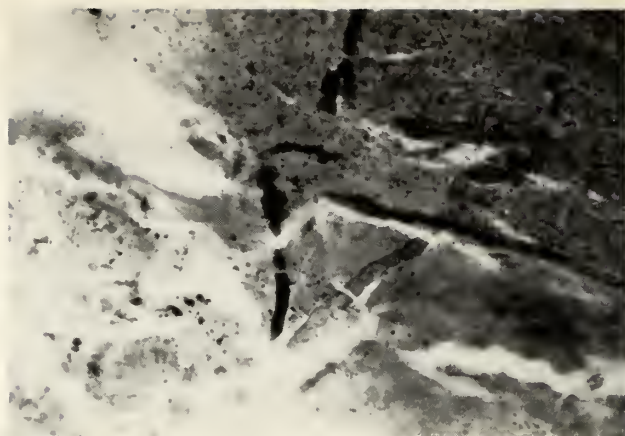


Figure 2—Positive biopsy for rhino-mucormycosis characterized by broad, non-septate hyphae seen with H. & E. stain.



Figure 3—Complete central retinal artery occlusion in affected eye.

Up to this point the clinical picture had remained basically the same, but vision was limited to light perception. Fundus examination revealed the classic picture of a total central retinal artery occlusion with ischemic infarction of the retina. (Figure 3) Amphotericin B was started at a dose of 10 mg. on day one and increased by 10 mg. daily to 50 mg. every day. Eye motility improved and the swelling decreased markedly after three days of therapy. Cultures of the eye and nasal passages grew *E. coli*. The patient continued to improve with a lessening of pain, swelling and fever. On day 38, ocular motility returned to normal. An ethmoidectomy and maxillary sinusotomy were performed on day 74 because of repeatedly positive biopsy evidence of mucormycosis. The patient's condition improved steadily and she was discharged on day 83. The total dosage of amphotericin B was 2105 mgm. when the last dose was given on day 75. The BUN fluctuated from 12 to 34 mg/dl and the creatinine from 0.6 to 2.1 mg/dl. All chemistries and urine examinations were normal at discharge.

The patient has been followed for nearly six months since

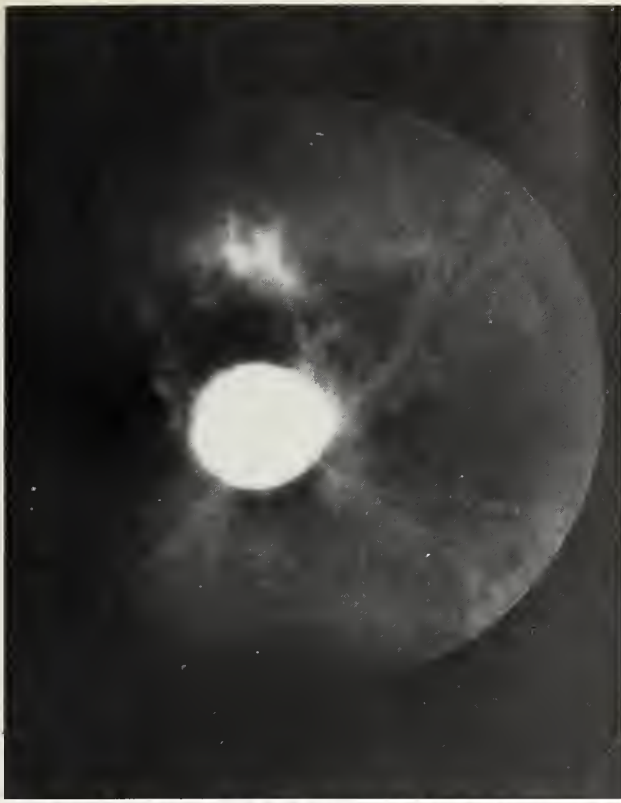


Figure 4—Blind affected eye with total optic atrophy following arterial occlusion.



Figure 5—Normal ocular appearance six months following discharge.

discharge. The right eye is normal and the affected left eye has no light perception due to total optic atrophy. (Figure 4) Ocular motility facial appearance are normal with no proptosis. (Figure 5)

DISCUSSION

Acute phycomycosis (mucormycosis), is a fungal infection with high mortality. Complete descriptions of the class phycomycetes are found in the literature.^{1,2} The mycopathology of this disease derives from the phylum Thallophyte which is divided into two main groups, the algae (containing chlorophyll) and the fungi. The fungi include Eumycetes (true fungi) and pseudomycetes. The former is classified as Phycomycetes, the Basidiomycetes, the Ascomycetes, and the Fungi Imperfecti. The latter class contains most of the pathogens with which we are familiar. The fungus responsible for "cerebral mucormycosis" is in the class Phycomycetes, order Mucorales, family Mucoraceae. There are two genera in Mucoraceae—Mucor and Rhizopus. To date, Mucor has never been cultured from a case of cerebral mucormycosis whereas Rhizopus has been cultured in several cases. It is this finding that led to the more accurate term *Cerebral Phycomycosis*.

At least 50 percent³ of the cases are associated with diabetes mellitus and most of these have acidosis. Meyer *et al*⁴ noted that the rhinocerebral form is associated with diabetes, the pulmonary or disseminated form occurs in burn patients and the intestinal form in non-compromised patients. Phycomycosis occurs rarely in healthy persons but is associated with leukemia, carcinoma, severe burns, renal diseases, and anemia. Several cases have been reported in patients treated with antimetabolites, radiation, antibiotics, and steroids.⁵

The clinical picture of acute mucormycosis is well de-

scribed;^{1,2} over ninety-one cases^{1,2,4,6-9} are reported in reviews and case reports. Less than one-third of these patients have survived^{1,2,4,10} although some decrease in mortality has been noted since the introduction of amphotericin B in 1955.¹¹

Typically, the fungus invades the nasopharynx, extends to the paranasal sinuses, and then reaches the orbit. Involvement of the brain may ensue by direct spread along the arteries and nerves. The fungus has a propensity for arteries and combines with an intense polymorphonuclear infiltrate to cause thrombosis of major vessels including the internal carotid and ophthalmic arteries.

Clinically, the ocular findings include proptosis, homolateral ophthalmoplegia, lid edema, conjunctival chemosis, and severe vision loss. The involvement of major blood vessels may lead to a picture of cavernous sinus thrombosis. This characteristic picture should lead to aggressive diagnostic procedures including immediate biopsy of the nasal mucosa, even with frozen section. Grossly, a dark, gangrenous nasal mucosa is an important finding. Several specimens must be examined histopathologically to make the diagnosis. Positive culture is unknown with Mucor and is rare with Rhizopus.

Initially, the underlying disease should be treated vigorously, as the diabetic ketoacidosis was in this case. Often these patients remain severely toxic and develop local signs related to the nasopharynx, sinuses, orbits, and nervous system. Prompt initiation of intravenous amphotericin B plus aggressive surgical debridement of the turbinates and sinus mucosa, as well as supportive medical therapy are essential to save life. The vascular involvement in the eye by the fungus invariably causes permanent blindness, but it is possible to retain the globe.

SUMMARY

An uncontrolled diabetic in acidosis developed signs and symptoms of cavernous sinus thrombosis. A diagnosis of phycomycosis was suspected and nasal mucosal biopsies showed typical nonseptate hyphae. Amphotericin B therapy was initiated and the nasal-sinus mucosa later was surgically debrided. The patient survived although she completely lost the vision of the eye. Evidence of decreased vision and orbital inflammation in debilitated patients and in patients with diabetic acidosis should lead to a suspicion of ocular phycomycosis. This case re-emphasizes (1) the importance of early diagnosis and aggressive treatment and (2) the ocular findings which are present in over 80 percent of patients with rhino-cerebral mucormycosis.¹

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Mr. Richard Press provided the photographs for this report.

DESCRIPTION: Methyltestosterone is 17 β -Hydroxy-17-Methylandrosta-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunuchism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric,

avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE**

REACTIONS: Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. In the male: Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchidism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahoglu, M.D.; Hormones for Improved Sexuality in the Male and the Female Climacteric. *Drug Therapy*, Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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Please consult complete prescribing information, a summary of which follows:

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"Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.

Final classification of the less-than-effective indications requires further investigation.

Contraindications: Glaucoma, prostatic hypertrophy, benign bladder neck obstruction; hypersensitivity to chlordiazepoxide HCl and/or cimetidine Br.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

Use in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.

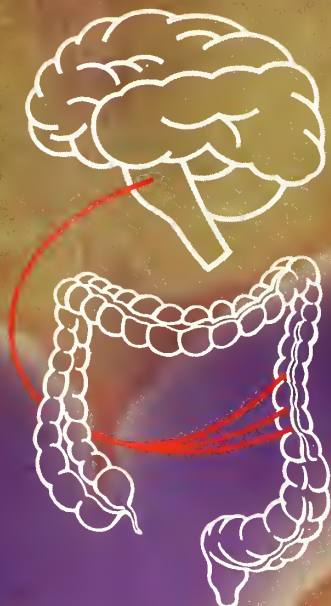
As with all anticholinergics, inhibition of lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated, avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment, blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, i.e., dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

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*Librax has been evaluated as possibly effective for this indication.
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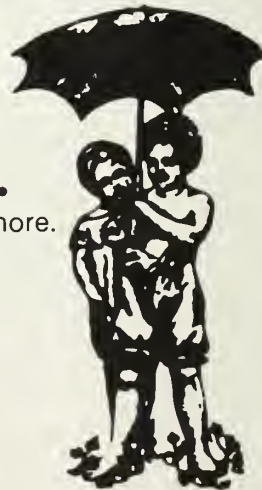
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The Pregnant Adolescent: A High-Risk Patient

MARCO ANTONIO PELOSI, M.D.,
JOSEPH APUZZIO, M.D.,
T. S. LI, M.D., Newark

During the teen years pregnancy is a problem of major medical, psychosocial, and economic proportions. Present national trends reflect that the birth rate for adolescents is rising in contrast to that for all other age groups. This review emphasizes that these patients are at higher risk than older pregnant women. Similarly, their offspring are at greater risk during intrauterine life and later.

Pregnancy in the teen years is a problem of major medical, psychosocial, and economic proportions. It is estimated that there are some 50,000,000 teenagers in this country. Approximately 600,000 teenagers give birth every year in the United States. Today's adolescents are accounting for one of every five births, nationally.¹

Present national trends reflect that the birth rate for young teenagers is rising, in contrast to that for all other age groups. Approximately 10 percent of 13 year olds, 17 percent of 14 year olds, 24 percent of 15 year olds and 31 percent of 16 year olds are active sexually, according to recent studies,² and the sexually active no longer are confined to low income or minority groups. If we add to this number of pregnant adolescents the men involved, the babies born, and their families, the great dimensions of this problem clearly can be recognized.

OBSTETRICAL ASPECTS

The pregnant adolescent is at a higher risk than an older woman during pregnancy, labor, and delivery. Similarly, the offspring of the teenager is at a greater risk during fetal life and the neonatal period. There is an increased newborn death rate and the maternal mortality rate is higher in the teenage group. In 1973 in the United States, the maternal mortality rates were 4.67 per 10,000 births in women under age 15, 1.19 per 10,000 births in women 15-19 years old, and 0.92 per 10,000 in women 20-24 years old.² The contribution

of age itself, as opposed to the availability and utilization of services, race, socio-economic conditions, marital status, and general health is uncertain. A woman of 16 to 19 years of age usually will perform as well obstetrically as a woman between the ages of 20 to 29. However, pregnant women under the age of 16 are potentially high risks.³

The literature shows that the incidence of hypertensive disorders of pregnancy, including toxemia, as well as the risk of abruptio placentae is greater among adolescents.³⁻⁷ The critical age for high risk of feto-pelvic disproportion due to pelvic immaturity appears to be between 14 and 15 years. There is a three to four-fold risk of perinatal deaths and/or prematurity for the offspring of mothers with inadequate prenatal care compared to those with adequate care, and similar risk with decreased maternal age and socio-economic status. There is a higher risk of neurological deficit at one year of age in the offspring of both very young and very old mothers. Pregnancy imposes additional needs for calories and nutrients which many teenage pregnant do not satisfy. There is a high incidence of maternal anemia and of infants who are underweight for gestational age. These small-for-date infants have more complications in the neonatal period

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and are more apt to show up with development problems during childhood. These usually indicate inadequate maternal nutrition. This may reflect the demographic characteristic of patients pregnant at an early age, rather than of adolescence itself.⁸

DEMOGRAPHIC, SOCIO-ECONOMIC, AND PSYCHOLOGICAL ASPECTS

The young teenage mother is usually poor, of a minority group, and is medically, nutritionally, and psychologically unsophisticated. However, it should be emphasized that there is an increased number of adolescent pregnancies which no longer are confined to low income and minority groups. Pregnancy is the most common reason for young women to leave school. Fifty per cent of female high school drop-outs are pregnant.^{1,9} Pregnant adolescents are more likely to come from single-parent homes and to have many brothers and sisters. Three out of four pregnant teenagers are not married. The pregnant adolescent in general receives less prenatal care than older women, by fewer visits and by starting prenatal care later in pregnancy.

Reasons suggested included denial of pregnancy, ignorance as to the need for care, inappropriate methods of service delivery, and psychological factors.^{3,6} It is not unusual to find that a teenager does not appear at the hospital until her pregnancy is complicated or she is in labor.

DISCUSSION

The pregnant adolescent represents a complex person who has medical, social, psychological, and economic problems. Because of these problems, a multidisciplinary approach is necessary if health professionals are best to serve the young mother. Special programs should provide comprehensive services for the pregnant adolescent.¹⁰

Ideally, the multidisciplinary team should be composed of:

- a) Medical Team: obstetrician, nurse specialist, pediatrician (newborn specialist), pediatrician (adolescent specialist) and dietitian.
- b) Psychosocial Team: psychiatric social worker, psychiatrist (consultative) and occupational therapist.
- c) Educational Team: teachers.

Such special programs have contributed markedly to the reduction of morbidity and mortality in the teenage mother and baby, and they have been shown to reduce significantly the incidence of complications when compared to groups of teenagers not using multidisciplinary comprehensive care.^{1,2,7,11,12} These programs give the adolescents the security and support of being with other girls in the same situation, rather than feeling out of place or stigmatized as they might in a general obstetrical clinic. Other problems of immediate concern associated with teenage pregnancy include the alternative of abortion, keeping the infant or placing it for adoption. Counseling should be available to the patient, the father, and, when appropriate, to the parents of the teenagers before these difficult decisions are made. It should be emphasized that a number of issues are significant and peculiar to the problems of adolescent abortion. Late abortion due to fear or ignorance is frequent. Post-abortion anxiety and depression are not unusual in an adolescent.⁶ An effort should be made to help the patient to understand the importance of seeking appropriate community services and/or programs which will help her complete her educational goals and assist in solving her problems. Otherwise a vicious cycle is initiated which includes teenage pregnancy, school drop-outs, incomplete education, poor earning poten-

tial, welfare status, and repeated pregnancy. The outlook of marriage is grim and usually ends in divorce.

Assistance often is needed in helping the patient and her family cope with the problems of pregnancy and in reaching mutually compatible decisions. Psycho-social support, counseling, and directive guidance are essential as the teenage patient is confronted with the responsibilities of rearing children. Counseling should involve the father of the child so that he too can adjust more easily to his new responsibilities.

The continued surveillance by the medical care team of the problems of teenage pregnancy should not be diminished even if the patient marries.¹³

Private physicians should consider the advantages of these programs. They should investigate the availability in their area of these programs and refer their teenage patients for psycho-social support, while retaining responsibility for medical care. If such a program is not available, they should consider establishing one.

The basic need for contraception in the adolescent only recently has been recognized in the family planning movement in America and abroad. With the abortion laws liberalized, termination of pregnancy has become a widely used method of solving the problem of unwanted pregnancy in teenagers. However, for those who choose to continue the pregnancy, a multidisciplinary program is essential to ensure a good outcome for the mother and baby.

SUMMARY

Pregnancy is a problem of major medical, psychosocial, and economic proportions. Present national trends reflect that the birth rate for adolescents is rising in contrast to that for all other age groups. This review emphasizes that these patients are at higher risk than older pregnant women. Similarly, their offspring are at greater risk during intra-uterine life and later. The obstetrical, demographic, socio-economic, and psychological aspects are discussed.

The need of special programs that provide comprehensive services for the pregnant adolescent is emphasized. The use of multidisciplinary teams has contributed markedly to the reduction of morbidity and mortality in the teenage mother and her baby and has been shown to reduce significantly the rate of complications.

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Indications: Although the principal indication for cloxacillin sodium is in the treatment of infections due to penicillinase-producing staphylococci, it may be used to initiate therapy in such patients in whom a staphylococcal infection is suspected. (See Important Note below.)

Bacteriologic studies to determine the causative organisms and their sensitivity to cloxacillin sodium should be performed.

Important Note: When it is judged necessary that treatment be initiated before definitive culture and sensitivity results are known, the choice of cloxacillin sodium should take into consideration the fact that it has been shown to be effective only in the treatment of infections caused by pneumococci, Group A beta-hemolytic streptococci, and penicillin G-resistant and penicillin G-sensitive staphylococci. If the bacteriology report later indicates that the infection is due to an organism other than a penicillin G-resistant staphylococcus sensitive to cloxacillin sodium, the physician is advised to continue therapy with a drug other than cloxacillin sodium or any other penicillinase-resistant semi-synthetic penicillin.

Recent studies have reported that the percentage of staphylococcal isolates resistant to penicillin G outside the hospital is increasing, approximating the high percentage of resistant staphylococcal isolates found in the hospital. For this reason, it is recommended that a penicillinase-resistant penicillin be used as initial therapy for any suspected staphylococcal infection until culture and sensitivity results are known.

Cloxacillin sodium is a compound that acts through a mechanism similar to that of methicillin against penicillin G-resistant staphylococci. Strains of staphylococci resistant to methicillin have existed in nature and it is known that the number of these strains reported has been increasing. Such strains of staphylococci have been capable of producing serious disease, in some instances resulting in fatality. Because of this, there is concern that widespread use of the penicillinase-resistant penicillins may result in the appearance of an increasing number of staphylococcal strains which are resistant to these penicillins.

Methicillin-resistant strains are almost always resistant to all other penicillinase-resistant penicillins (cross-resistance with cephalosporin derivatives also occurs frequently). Resistance to any penicillinase-resistant penicillin should be interpreted as evidence of clinical resistance to all, in spite of the fact that minor variations in *in vitro* sensitivity may be encountered when more than one penicillinase-resistant penicillin is tested against the same strain of staphylococcus.

Contraindications: A history of a previous hypersensitivity reaction to any of the penicillins is a contraindication.

Warning: Serious and occasionally fatal hypersensitivity (anaphylactoid) reactions have been reported in patients on penicillin therapy. Although anaphylaxis is more frequent following parenteral therapy it has occurred in patients on oral penicillins. These reactions are more apt to occur in individuals with a history of sensitivity to multiple allergens.

There have been well documented reports of individuals with a history of penicillin hypersensitivity reactions who have experienced severe hypersensitivity reactions when treated with a cephalosporin. Before therapy with a penicillin, careful inquiry should be made concerning previous hypersensitivity reactions to penicillins, cephalosporins, and other allergens. If an allergic reaction occurs, the drug should be discontinued and the patient treated with the usual agents, e.g., pressor amines, antihistamines, and corticosteroids.

Safety for use in pregnancy has not been established.

Precautions: The possibility of the occurrence of superinfections with mycotic organisms or other pathogens should be kept in mind when using this compound, as with other antibiotics. If superinfection occurs during therapy, appropriate measures should be taken.

As with any potent drug, periodic assessment of organ system function, including renal, hepatic, and hematopoietic, should be made during long-term therapy.

Adverse Reactions: Gastrointestinal disturbances, such as nausea, epigastric discomfort, flatulence, and loose stools, have been noted by some patients. Mildly elevated SGOT levels (less than 100 units) have been reported in a few patients for whom pretherapeutic determinations were not made. Skin rashes and allergic symptoms, including wheezing and sneezing, have occasionally been encountered. Eosinophilia, with or without overt allergic manifestations, has been noted in some patients during therapy.

Usual Dosage: Adults: 250 mg. q. 6h.

Children: 50 mg./Kg./day in equally divided doses q. 6h. Children weighing more than 20 Kg. should be given the adult dose. Administer on empty stomach for maximum absorption.

NOTE: INFECTIONS CAUSED BY GROUP A BETA-HEMOLYTIC STREPTOCOCCI SHOULD BE TREATED FOR AT LEAST 10 DAYS TO HELP PREVENT THE OCCURRENCE OF ACUTE RHEUMATIC FEVER OR ACUTE GLOMERULONEPHRITIS.

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BRIEF SUMMARY

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Precautions: Potassium intoxication by oral administration rarely occurs in patients with normal kidney function, however, potassium supplements must be administered with caution, since the amount of the deficiency or daily dosage is not accurately known. Frequent checks of the clinical status of the patient, and periodic ECG and/or serum potassium levels should be made. High serum concentrations of potassium ion may cause death through cardiac depression, arrhythmias or arrest. This drug should be used with caution in the presence of cardiac disease.

In hypokalemic states, especially in patients on a low-salt diet, hypochloremic alkalosis is a possibility that may require chloride as well as potassium supplementation.

Adverse Reactions: Nausea, vomiting, diarrhea, and abdominal discomfort have been reported. The most severe adverse effect is hyperkalemia.

Overdosage: Potassium intoxication may result from overdosage of potassium or from therapeutic dosage in conditions stated under "Contraindications". Hyperkalemia, when detected, must be treated immediately because lethal levels can be reached in a few hours.

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Complex Gastrointestinal Fistulae

RALPH S. GRECO, M.D., Green Brook*

Six patients with complicated gastrointestinal fistulae are presented. Greater emphasis on the role of surgery in these conditions is necessary. TPN is a valuable therapy for GIF and in simple fistulae will result in spontaneous closure. Complicated fistulae associated with distal obstruction, intraperitoneal abscesses, and involvement of multiple viscera usually will require definitive surgical correction as well as total parenteral nutrition.

Despite the effective use of total parenteral nutrition (TPN), gastrointestinal fistulae continue to exact a tragic toll in surgical patients. Morbidity and mortality remain high. The length and cost of hospitalization and psychological effect on patient and family can be overwhelming. Complex fistulae involving multiple internal organs compound these problems significantly.

The extensive literature, recently amassed, in total parenteral nutrition and the associated improvement in management of gastrointestinal fistulae have defined clearly the place of TPN in the treatment of this serious problem, but many fistulae still require surgical management.^{1,2,3,4} Though TPN is associated with the spontaneous closure of some fistulae, especially small, simple ones, and it has obviated the serious complication of fluid imbalance and nutritional deficiencies, surgery still plays a critical role in fistulae which remain patent in spite of TPN, and those associated with distal obstruction, persistent sepsis, gastrointestinal discontinuity, abdominal wall defects, and multiple internal communications.

Among the fistulae treated at CMDNJ-Rutgers Medical School-Raritan Valley Hospital recently, six cases are presented in support of this contention.

CASE HISTORIES

Case 1—A 55-year-old female underwent a laparotomy and was found to have perforated diverticulitis for which a

colostomy was performed. Post-operatively, she developed a small bowel fistula and was transferred to Raritan Valley Hospital for hyperalimentation. She was treated with nasogastric suction, intravenous fluids, and antibiotics. Hyperalimentation was begun. Gastrointestinal series revealed an ileocutaneous fistula with partial distal obstruction.

Despite 3000 to 5000 calories per day for five weeks, her fistula did not heal. Because of this she underwent resection of the fistula with end-to-end anastomosis of the small bowel and revision of her colostomy. Her post-operative course was unremarkable. She was discharged home on May 28, 1976. Because of her poor general health, no attempt has been made to resect the involved sigmoid colon and close the colostomy.

Case 2—A 65-year-old female had undergone a Whipple procedure in 1965 for a mass in the head of the pancreas which apparently turned out to be pancreatitis. On June 3, 1976, she developed shaking chills and fever, and was admitted to the medical service with the diagnosis of an acute exacerbation of rheumatoid arthritis. On June 12, 1976, she developed increasing right upper-quadrant tenderness and hypotension. Surgical consultation was obtained and a mass was found in the right upper quadrant. Her sepsis was appropriately treated and surgery performed later the same

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Figure 1—The barium enema performed in patient #2 demonstrating communication between the transverse colon, the small bowel, the abscess cavity and the gallbladder.

day. A huge abscess was found in the right subhepatic space caused by a two by two mm. perforation of the jejunum, three cm. distal to the cholecystojejunostomy. The right upper quadrant was drained, the fistula was closed, and a cholecystostomy performed. Her course was complicated by the appearance of bilious drainage via the drains on the eighth post-operative day. An upper gastrointestinal series revealed a fistula in the area of the previous perforation and this was corroborated by tube cholecystogram. She was begun on hyperalimentation and for the next month, appeared to be improving. However, on July 16, she became septic and the drainage from the fistula appeared feculent. A barium enema revealed a fistula involving not only the biliary tract and jejunum, but also the right transverse colon (Figure 1). On July 22, she was taken back to the operating room, but complete resection of these fistulae could not be performed. The right upper quadrant was drained and tubes placed in the gallbladder, the jejunum and in the colon. On July 27, she became septic again and a liver scan and Gallium scan revealed multiple liver abscesses which were confirmed by angiography. The patient had a persistent downhill course and expired on August 11, 1976.

Case 3—A 63-year-old female was admitted with obstructive jaundice. At operation, an ampullary carcinoma was found and the patient underwent a total pancreaticoduodenectomy. On the fifth post-operative day, she developed bilious drainage from the drains in the right upper quadrant and was transferred to Raritan Valley Hospital for total parenteral nutrition. An upper gastrointestinal series showed



Figure 2—A sinogram in patient #3 demonstrating the biliary tract in the right upper quadrant and an abscess cavity which communicates with the pancreatic duct seen in the left mid epigastrium.

a large abscess communicating with the skin, the gastrojejunostomy and the choledochojejunostomy. She was operated on and the fistula was excised and the bowel closed in two layers. A tube choledochostomy was performed as well as a feeding jejunostomy. Post-operatively the patient was fed via the jejunostomy supplemented with intravenous hyperalimentation. The patient then had multiple episodes of gastrointestinal bleeding and gastroscopy revealed a marginal ulcer. A trans-thoracic vagotomy was performed. This controlled the bleeding but despite parenteral and intestinal hyperalimentation, the fistula remained open. A sinogram now revealed another communication with the transverse colon. The patient's abdomen was reexplored. The entire upper gastrointestinal tract from the stomach to the previously placed feeding jejunostomy could be mobilized and resected. Abscesses in the left upper and right upper quadrants were drained. A side-to-side cholodochojejunostomy and side-to-side gastrojejunostomy were performed. Because amylase had been measured in the fistula drainage, a search was made for pancreatic tissue. However, the retroperitoneum was a solid mass of inflammatory tissue and her precarious condition dictated that further dissection be abandoned. The patient did well and her condition stabilized. She began to eat and gain weight for the first time in five months. However, a repeat study through the tract of the cholococho tube now revealed a structure in the mid-epigastrium which looked very much like a pancreatic duct (Figure 2). Since the patient was doing well, it was elected not to do anything at that time. Suddenly, on July 12th, the patient became septic and jaundiced. A repeat choledochogram showed the pancreatic duct and recurrence of the fistulae. She was re-explored. At this time, there was a dense plastic peritonitis allowing only drainage of the right and left upper quadrants and the retroperitoneum. The patient grew worse and expired on July 30, 1977. An autopsy revealed that the body and tail of the pancreas remained in the retroperitoneum surrounded by a dense retroperitonitis characterized by fat necrosis and multiple fistulae from the retained pancreas to surrounding structures.

Case 4—A 62-year-old female was operated on and found to have perforated diverticulitis with an abscess in the left lower quadrant. She underwent a colostomy and drainage of the abscess. Post-operatively she developed a small bowel fistula. This was treated with nasogastric suction, hyperalimentation, and antibiotics, but without healing. On admission to Raritan Valley Hospital, she was begun on intra-

venous hyperalimentation through the jugular vein because a subclavian route could not be established. In March of 1976, because of the inability to maintain an intravenous hyperalimentation line, a bovine shunt was placed in the left leg between the left common femoral artery and left saphenous vein and hyperalimentation was satisfactorily achieved. Seven weeks after admission, the right lower quadrant fistula persisted. On April 19, 1976, she was operated upon and found to have multiple fistulous tracts from the jejunum to the skin. She underwent a small bowel resection with end-to-end anastomosis. One month later, she was discharged after an uneventful post-operative course.

Case 5—A 55-year-old male was admitted with symptoms of an acute abdomen. The patient underwent an exploratory laparotomy at which time the surgeon found the entire small bowel to be inflamed, without infarction, and there were good mesenteric pulsations. The abdominal cavity was therefore closed. Post-operatively, the patient developed acute renal failure treated by peritoneal dialysis. During dialysis, feculent material was obtained from the peritoneal catheters. The patient was transferred to Raritan Valley Hospital for hyperalimentation. At that time, physical examination revealed a fecal fistula in the right lower quadrant. The patient's white blood count was 25,700. He was begun on intravenous hyperalimentation. His renal failure gradually resolved but he also began to have necrotic material emanating from the fistula in the right lower quadrant. Therefore, on the third day after transfer to Raritan Valley Hospital, he was taken to the operating room. The entire small bowel except for two feet of proximal jejunum was found to be autolyzed. A jejuno-ascending-colostomy was performed and the terminal ileum was brought out to the skin as a mucous fistula. Post-operatively, the patient had a very stormy course. He was begun on TPN of 3,000-5,000 calories per day and gradually improved. By July 27, 1975, his hyperalimentation was stopped and he was advanced to a regular diet and discharged.

Case 6—A 19-year-old male was admitted with a self-inflicted abdominal gunshot wound. The left lower abdominal wall was avulsed. At laparotomy, a small bowel resection was performed as was a left colectomy and colostomy. His post-operative course was complicated by sepsis and peritonitis. He developed small bowel obstruction; an ileectomy with lysis of adhesions was performed. Marlex mesh was placed in the abdominal wall defect. His post-operative course was complicated by a small bowel fistula. He was transferred to Raritan Valley Hospital on March 7, 1977. Intravenous hyperalimentation was started. Daily caloric intake was 4,000-5,000 per day. The patient began to gain weight and additional calories were given by mouth with elemental diet.

Two months later, his fistula remained open and he was operated on and the fistula closed locally. Post-operatively, it recurred but intravenous hyperalimentation was stopped and the patient placed on a regular diet. He was discharged because the drainage from the fistula could be controlled with a pressure dressing and it was hoped it would close spontaneously. He did well, but was readmitted with one small fistula present as well as the previous colostomy and mucous fistula. He was operated upon again and resection of the fistula and small bowel with end-to-end anastomosis performed as well as a colocolostomy. Marlex mesh was used to close the abdominal wall defect. He was continued on TPN and his wound granulated quickly. One week after surgery he was begun on a regular diet. A split thickness skin graft

completed the closure of his wound and on September 30, 1977, he was discharged.

DISCUSSION

Treatment of gastrointestinal fistula (GIF) prior to the advent of total parenteral nutrition was rarely successful because of attendant electrolyte imbalance and malnutrition. While it is the general impression of the surgical community that morbidity and mortality have decreased in the TPN era and that impression is supported by reliable data, it is equally true that the decrease in mortality in GIF may be influenced by other factors, such as improved cardiopulmonary support and antibiotics directed against anaerobic bacteria.

In 1973, McPhaydren and Dudrick reported a series of GIF treated with hyperalimentation; they obtained spontaneous closure in 70 percent of cases.² Aquirre *et al.*⁶ suggested that surgery still played an important role in the management of GIF especially in the presence of intra-abdominal abscesses, distal obstruction, and disruption of intestinal continuity. Only eleven of their 38 patients closed their fistulae spontaneously and the remainder required surgical intervention.

The six patients described in this report illustrate the complexity of the problem, the supportive but not definitive role of TPN, the necessity for radiological evaluation of the extent of the pathological process, the value of gastrointestinal alimentation and the essential role of definitive surgery.

The first patient's course emphasizes that fistulae will not close in the face of distal obstruction and that early radiological evaluation of fistulae preferably via the gastrointestinal tract and the external sinus is mandatory. As soon as complete radiological study has been completed, abscesses have been drained, and TPN has resulted in weight gain, definitive surgical intervention should be pursued. The second case history is illustrative of the pitfalls inherent in the management of patients with multiple system pathology. The attempt to treat this complicated problem with one operation is more often fraught with failure than it is rewarded with success. Treatment with division and exteriorization of the cholecystojejunostomy would have been preferable though it would have necessitated a second operation. Despite vigorous hyperalimentation and drainage, the fistulae in this patient and the third patient were complicated by extension into the transverse colon. Case #3 also emphasizes the association of GIF with technical errors. TPN served to obviate the classical complication of malnutrition, but without the benefit of definitive surgical excision of the retained pancreas, the patient died. The use of gastrointestinal alimentation via a jejunostomy is specifically applicable to the patient with a fistula proximal to the ligament of Treitz and, in the author's opinion, is the procedure of choice in these conditions.

The fourth case points out another role of surgery in GIF. The low fistula required TPN rather than intestinal alimentation, but an adequate route could not be established and maintained. The use of a vascular access procedure accomplished this goal and after the patient's general condition improved, definitive surgical excision could be accomplished.

The fifth case again illustrates the need for early definitive surgery in GIF. Presumably, the patient had mesenteric arterial or venous thrombosis which was not observed at the first operative procedure. It is possible that his bowel was perforated during peritoneal dialysis and the attendant fecal

peritonitis resulted in bowel autolysis. The external sinus gave little evidence of the catastrophic events occurring in the peritoneal cavity. Persistent TPN would not have changed the outcome. However, definitive surgical correction followed by TPN resulted in a successful result. The sixth case is another example of the complex GIF. Though the small bowel fistula itself might have closed spontaneously with TPN in the absence of associated pathology, the abdominal wall avulsion and colostomy made surgery mandatory. The tedious process of decreasing the fistula output with local closure allowed sufficient wound healing to occur before the final definitive correction. Only after fistula closure and colostomy closure could wound closure have been successfully concluded.

Gastrointestinal fistula is a catastrophic illness which requires methodical treatment if success is to be achieved. Total parenteral nutrition creates a milieu in which some fistulae will close spontaneously and others will respond to surgical correction. Gastrointestinal fistulae associated with persistent sepsis and abscesses, distal obstruction, complete intestinal disruption and multiple internal communications should be treated with TPN and corrective surgery.

Surgery has still other roles in the treatment of gastrointestinal fistulae. Patients with fistulae proximal to the ligament of Treitz often can be alimented satisfactorily via the gastrointestinal tract after surgical placement of a tube jejunostomy. This form of nutrition is more physiologic than TPN and is associated with fewer metabolic complications. The combined use of TPN and gastrointestinal alimentation can provide 5,000 calories per day with fewer difficulties than either procedure used independently. Certainly the placement of a tube jejunostomy at the time of esophago-gastric and biliary-pancreatic procedures associated with post-operative fistulae is recommended.


Finally, the use of surgery to enhance the benefit of TPN should not be ignored. Venous cutdowns and vascular access procedures are, after all, part of the surgical armamentarium and we should not lose sight of their applicability.

SUMMARY

Six patients with complicated gastrointestinal fistulae are presented. Greater emphasis on the role of surgery in these conditions is necessary. TPN is a valuable therapy for GIF and in simple fistulae will result in spontaneous closure. Complicated fistulae associated with distal obstruction, intraperitoneal abscesses and involvement of multiple viscera usually will require definitive surgical correction as well as total parenteral nutrition.

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Staphylococcus Epidermidis Endocarditis: Case Reports and Review of the Literature

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Two patients with surgically confirmed *Staphylococcus epidermidis* are described. In both patients, blood cultures grew out this bacterium. Blood cultures positive for *Staphylococcus epidermidis* should not be discarded as contaminants unless a thorough search for infective endocarditis has been carried out.

We recently treated two patients with infectious endocarditis (I.E.) and severe left ventricular failure. Multiple blood cultures obtained from both patients were sterile except for one culture in each patient which grew out *Staphylococcus epidermidis*, one of the most common contaminants of blood cultures.¹ In one instance, *Staphylococcus epidermidis* was considered to be a contaminant. In the other, it was considered to be a probable etiological agent. Cultures of surgically excised valves in both patients grew out pure cultures of *Staphylococcus epidermidis*. We are reporting our experience with these two patients to alert the practicing physician to the potential pathogenicity of this organism, and to emphasize that blood cultures positive for *S. epidermidis* should not be discarded as a contaminant until a thorough search for endocarditis has been carried out.

CASE REPORTS

Case #1—A 62-year-old man was well until one month prior to hospitalization on September 8, 1976. He noted fever, chills, and progressively severe dyspnea on exertion, orthopnea, and pedal edema. There was no history of acute rheumatic fever nor of a previous heart murmur. On physical examination, the patient was dyspneic at rest. The blood pressure was 140/60 mm. Hg. The pulses were bounding in quality. The neck veins were distended to the angle of the jaw at 60 degrees. Bibasilar moist rales were present. A left ventricular heave was present. The murmurs of aortic

stenosis and insufficiency were heard. The liver was enlarged. Bilateral pitting edema was found to the knees. Intermittent, spiking fevers were noted shortly after admission. Multiple blood cultures were obtained. One culture was positive for *S. epidermidis*, which was considered to be a contaminant. Despite digitalization and the use of diuretics, intractable biventricular failure developed. An echocardiogram, performed because of the suspicion of infectious endocarditis, revealed vegetations on the aortic valve. Cardiac catheterization and coronary arteriography substantiated the diagnosis of isolated, severe aortic insufficiency. At surgical exploration on October 1, 1976, multiple vegetations and fenestrations were noted in all three leaflets of the aortic valve. The aortic rim was narrowed, consistent with congenital aortic stenosis. Culture of the valves revealed a pure growth of *S. epidermidis*. The patient made an uneventful recovery following aortic valve replacement and a three-month course of antibiotics. Treatment consisted of a six-week course of oxacillin sodium (Prostaphlin-Bristol*) one gram every two

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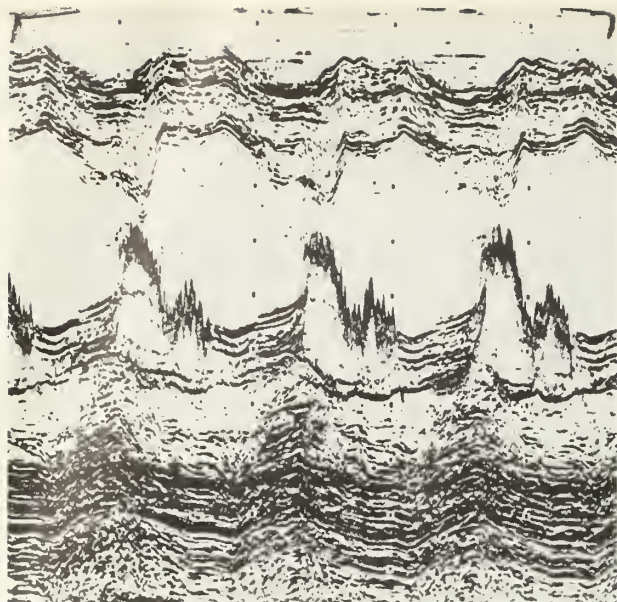


Figure 1—Echocardiogram of the mitral valve in case #1 demonstrating high frequency fluttering of the anterior leaflet of the mitral valve consistent with aortic insufficiency.

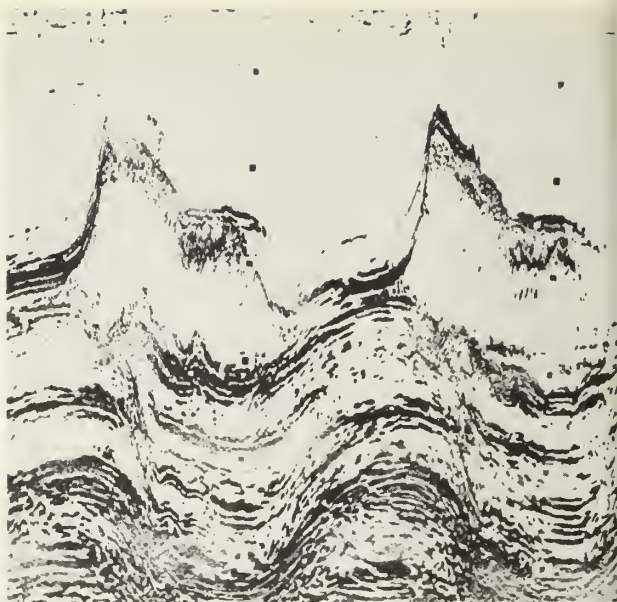


Figure 2—Echocardiogram of the mitral valve in case #2 demonstrating in addition to diastolic fluttering of the anterior leaflet, thickened shaggy echoes on both the anterior and posterior leaflet consistent with the vegetations of infective endocarditis.

hours intravenously, followed by a six-week course of same drug, administered one gram every six hours orally.

Case #2—A 45-year-old male was well until 1972 when he fractured his right tibia, which required several operative procedures. On several occasions, he was treated for osteomyelitis due to an unknown organism. Eighteen months prior to this admission, the patient was hospitalized for acute pulmonary embolization which was treated successfully with anticoagulation. Three months prior to admission he was hospitalized elsewhere in congestive heart failure which responded to digitalis and diuretic therapy. Two months prior to admission, he was rehospitalized for severe biventricular heart failure. Intermittent spiking fevers accompanied by chills were noted on this admission. Multiple blood cultures were obtained and one culture grew out *S. epidermidis*. The diagnosis of infectious endocarditis was made, and *S. epidermidis* was considered to be the etiologic agent. Despite a long course of high dose oxacillin therapy—one gram oxacillin sodium (Prostaphlin-Bristol®) intravenously every two hours—and defervescence, the patient developed intractable biventricular failure. He was transferred to the Newark Beth Israel Medical Center on October 15, 1976 for further study. There was no history of acute rheumatic fever nor knowledge of a heart murmur.

On physical examination, the patient was mildly dyspneic at rest. The blood pressure was 110/50 mm. Hg. The pulses were bounding in quality. The neck veins were engorged at 60 degrees. There were bibasilar moist rales. On palpation of the heart, a left ventricular heave was noted. A regular sinus rhythm was present. A high-pitched pansystolic murmur of mitral insufficiency was heard best at the apex. A rough, early to mid-diastolic decrescendo murmur was heard at the left sternal border. A summation gallop was heard at the apex. The liver was not enlarged. Pitting edema was noted bilaterally to the level of the knees.

An echocardiogram revealed vegetations on the aortic valve and the adjacent aortic wall. Cardiac catheterization and coronary arteriography revealed severe aortic and mitral insufficiency, associated with severe biventricular failure. At surgical exploration the mitral valve was severely damaged

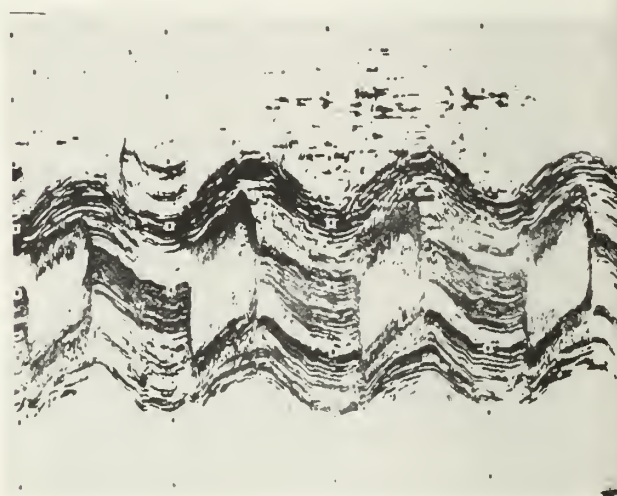


Figure 3—Echocardiogram of the aortic valve in case #2 demonstrating thickened shaggy echoes throughout the cardiac cycle consistent with infective endocarditis. These findings are similar to those observed in case #1.

with large vegetations covering the anterior and posterior leaflets which were thickened. The chordae tendineae were shortened and thickened. The aortic leaflets were also thickened and demonstrated large areas of fenestration in all leaflets. There was partial detachment of the right coronary cusp. The pathologic diagnosis was rheumatic heart disease with superimposed infectious endocarditis. The patient expired shortly after surgery because of left ventricular failure.

DISCUSSION

S. epidermidis is an organism which produces white or cream-colored colonies on culture medium but never yellow or gold pigment which is characteristic of *S. aureus*. It can be distinguished from *S. aureus* by failure to ferment mannitol and its inability to synthesize coagulase.² Although *S. epidermidis* is an ubiquitous inhabitant of normal skin flora,³ it

rarely causes skin infections.⁴ It is one of the most frequently encountered contaminants in blood cultures.¹ Accordingly, early investigators considered *S. epidermidis* to be a non-pathogenic organism.² However, sporadic cases of infectious endocarditis due to *S. epidermidis* were reported prior to the antibiotic era.^{5,6,7,8}

Two patients with *S. epidermidis* infectious endocarditis were reported in a Boston City Hospital review prior to 1947.⁹ Between 1947 and 1953, after the widespread introduction of penicillin and streptomycin, in the same institution, 17 cases were recorded. This increased prevalence of *S. epidermidis* infectious endocarditis was thought to be related to its resistance to the commonly used antibiotics.

More recently, the era of open heart surgery ushered in an upsurge in the prevalence of *S. epidermidis* infectious endocarditis.^{10,11} Infectious endocarditis following open heart surgery may be divided into cases occurring in the immediate postoperative period and those occurring during the late postoperative period.¹² The majority of the cases occurring in the immediate postoperative period probably are related to intra-operative contamination.^{11,13} In one study 7.5 percent of routine blood cultures obtained during open heart surgery grew out *S. epidermidis*.¹⁴ Therefore, it is not unexpected that many cases of *S. epidermidis* infectious endocarditis reported after 1955 occurred in this clinical setting.

Heroin addicts are at high risk for development of *S. epidermidis* infectious endocarditis.^{15,16} In these cases, contamination through intravenous injections after faulty skin preparation is a likely cause of sepsis and infectious endocarditis.

Quinn and Cox¹⁷ recently described 16 cases of *S. epidermidis* infectious endocarditis, nine of which were not related to open heart surgery or heroin addiction. The clinical course of these nine patients was remarkably similar to the subacute presentation of infectious endocarditis due to *Streptococcus viridans*. In all these patients, endocarditis occurred on abnormal valves. In one patient, two blood cultures grew out *S. epidermidis* which were discarded as contaminants. This patient unfortunately was not treated with penicillin and died.

Our two patients extend the observations of Quinn and Cox.¹⁷ The clinical presentation of both patients was smoldering and characterized by intermittent fever, chills, and progressively severe left ventricular failure. Peripheral embolization was not a feature of either case. Although neither patient was aware of valvular disease, surgical exploration revealed underlying valvular disease in both. In both cases, at least one blood culture was positive for *S. epidermidis*. In one patient (patient #1), this culture was considered to be a contaminant and the diagnosis of infectious endocarditis was made by echocardiography because of the strong clinical suspicion of infectious endocarditis. Per-

haps, proper interpretation of the bacteriological data from this patient might have precluded surgical exploration. Despite proper therapy, the clinical course of patient #2 was characterized by progressive biventricular failure and death following aortic and mitral valve replacement.

CONCLUSION

We conclude that *S. epidermidis* infectious endocarditis is now a well-established clinical entity. Further, blood cultures positive for *S. epidermidis* should not be disregarded, especially in the patient whose clinical course resembles a subacute presentation of *Streptococcus viridans* endocarditis.

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Changes in Tuberculosis Incidence in Newark, New Jersey

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A. EMANUAL, J. W. LEVITT,
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This paper is a study of the striking decline in active tuberculosis rates in Newark. It was found that blacks and whites, men and women, and all age groups under 60 years shared in the decreased rates. The decline could not be explained by migration of cases from Newark to surrounding communities. The decentralization of the tuberculosis control program by closing the tuberculosis sanatorium in Essex County and concomitant augmentation of community-based, anti-tuberculosis activities and the amelioration of inner-city conditions is the most plausible explanation for the remarkable decline of tuberculosis in Newark.

Mortality and morbidity from tuberculosis began to decline before the discovery of antimicrobial drugs specific for tuberculosis. With the advent of chemotherapy in the late 1940's and early 1950's, the downtrend was greatly accelerated.¹ However, during the past five years, tuberculosis morbidity for the United States has changed very little.^{2,3} Larger cities appear to be more successful in reducing the incidence of tuberculosis than the small municipalities.^{2,4}

In 1969, the incidence of active tuberculosis in Newark was 69.2 compared to 19.4/100,000 population for the United States as a whole.^{5,6} This inordinately high rate established Newark as the city with the highest incidence of tuberculosis, a ranking that remained essentially unchanged through 1972. In 1973, the incidence of active tuberculosis in Newark fell to 58.0 and further decreased to 44.2/100,000 population in 1974,^{4,7} ranking Newark fifth for tuberculosis incidence among the 58 major American cities studied.^{4,7} This study is an attempt to explain the reasons underlying such a dramatic reduction in incidence over so short a period of time. In particular, the following questions seemed pertinent:

1. Was the decline in incidence seen in blacks as well as in whites? This is particularly relevant in Newark, a city with an ethnic distribution in 1970 of 54 percent black, 44 percent white, and the remaining 2 percent others.
2. Was the drop sex and/or age dependent?

3. Could the drop be due to migration of cases out of Newark?

MATERIALS AND METHODS

Two years, 1970 and 1974, were selected for analysis of tuberculosis incidence among Newark residents. The latter was the last year prior to the change in the definition of active tuberculosis for notification purposes, thereby preventing precise comparisons with subsequent years. The year 1970 was chosen as representative of the period during which the tuberculosis rates were particularly low.

Lists of all reported tuberculosis cases for 1970 and 1974 among Newark residents were obtained from the New Jersey State Department of Health. The demographic information for each case was collected from the Tuberculosis Services Unit of the New Jersey State Department of Health as well as from records of hospitals, clinics, and private physicians' offices from which the cases were reported.

The terms "active, quiescent, and inactive" cases used in the study are those defined by the National Tuberculosis and Respiratory Disease Association in 1969.⁸

In this study, the cases reported by the physicians as

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active or quiescent are classified under the active category. The inclusion of the quiescent cases in this study accounts for the differences between the rates in this study and the rates reported by the New Jersey State Department of Health and the Center for Disease Control^{4-7,9-12} as given in Tables 7 and 8 for Newark residents.

RESULTS

There were 374 and 264 new tuberculosis cases reported among the residents of Newark in 1970 and 1974 respectively. Of these, we were able to locate the medical records of 347 (93 percent) and 248 (94 percent) in 1970 and 1974 respectively. Of the 347 cases in 1970, 298 (86 percent) were active. Out of the 248 cases in 1974, 212 (85 percent) were active. In this study the analyses of patterns among active and inactive cases are based upon the 93 to 94 percent of the total reported cases for which records could be obtained. The total incidence rates have been calculated using the entire number of reported cases in each year.

Table 1 shows that the rate of active tuberculosis in Newark decreased 29 percent from 1970 to 1974. The rate of active tuberculosis decreased in New Jersey as a whole from 17.8 in 1970 to 13.7 per 100,000 population in 1974, a decrease of 23 percent. For the United States the rate decreased from 18.3 in 1970 to 14.2 per 100,000 population in 1974, a decrease of 22 percent.^{6,7} The actual decrease of 22.6 per 100,000 population of active tuberculosis in Newark was far greater than the 4.1 per 100,000 population observed in the State of New Jersey and the United States.

Considering only newly reported active cases, the greatest drop was found among black men (46.6/100,000 population), but the greatest percentage drop occurred among white women (48 percent) between 1970 and 1974 (Table 2). In contrast to active tuberculosis, the inactive tuberculosis rates declined by 39 percent among blacks, whereas there

was a 38 percent increase among whites (Table 3). This increase among whites occurred because of marked increase in rates among white women. However, this is of little significance as the number of cases is so small, totaling only 49 in 1970 and 36 in 1974.

As shown in Table 4, the age specific rates of active tuberculosis fell in both blacks and whites in each age group studied except for those over age 60, among whom rates remained essentially unchanged. The greatest decrease for both races was approximately 50 percent in the under 20 age group. In general, the reduction in rates decreased with advancing age.

The drop in rates may possibly be explained by a movement of new active cases to communities surrounding Newark. If this were true, cases originating in Newark would have caused an increase in cases reported from surrounding municipalities, and this should have been readily discernible since the number of cases in Newark far exceeds those found in the surrounding communities. This was not the case, as shown in Table 5. A decrease in tuberculosis was noted in all surrounding communities with the exceptions of East Orange, and Union and Morris Counties.

In these three communities a total increase of only 16 cases was reported; even if all 16 represented cases originated in Newark, this in no way could account for the decline of 126 cases in Newark between 1970 and 1974. (Note: The data in Tables 5 and 7 were obtained from the reports of the New Jersey State Department of Health and the Center for Disease Control^{4-7,9-12} and do not include the quiescent tuberculosis cases. This accounts for the differences between the Newark rate in Tables 5 and 7 and the reported cases in this study which includes both quiescent and active tuberculosis cases together in one category).

Sarcoidosis is thought by some to be related to parasitism by modified tubercle bacilli, and the incidence of sarcoidosis

Table 1
The Incidence of Active and Inactive Tuberculosis
in Newark 1970 and 1974

	1970		1974		Percentage decrease between 1970 & 1974
	Number	Rate *	Number	Rate	
Active	298	79.3	212	56.7	29
Inactive	49	13.0	36	9.6	26
Total (active & inactive)	347	92.3	248	66.3	28

* Based on 1970 population data, rates are expressed/100,000 population.

Table 2
The Reported Active Tuberculosis Incidence Rate
per 100,000 Population in Newark, 1970 and 1974

	1970	1974	Percent decrease from 1970-1974
White	34.4	23.2	32
Male	45.4	34.5	24
Female	24.2	12.7	48
Black	115.7	83.8	28
Male	165.0	118.4	28
Female	73.0	53.2	27

Table 3
Reported Inactive Tuberculosis Incidence
per 100,000 Population in Newark, 1970 and 1974

	1970	1974	Percent change between 1970 & 1974 *
White	4.8	6.6	+38
Male	4.9	4.9	0
Female	4.6	8.1	+76
Black	19.8	12.1	-39
Male	24.9	15.6	-37
Female	15.3	9.0	-41
Total	13.0	9.6	-26

* + means increase - means decrease

Table 4
The Age Specific Rate Changes of Newly Reported
Active Cases of Tuberculosis in 1970 and 1974, Newark

Years	AGE GROUPS				Total
	Under 20	20-39	40-59	60+	
1970:					
White	21.8	55.3	26.1	25.5	31.5
Black	34.2	157.5	189.7	203.2	106.0
Both Races	29.8	116.9	100.1	74.6	72.6
1974:					
White	10.9	40.4	16.7	25.6	16.1
Black	17.2	110.0	156.0	210.2	79.4
Both Races	15.0	82.3	79.6	79.5	53.7
Percentage change between 1970 and 1974*					
White	-50	-27	-36	0	-49
Black	-50	-30	-18	+3	-25
Both Races	-50	-30	-20	+7	-26

* + means increase - means decrease

Table 5
Active Tuberculosis Rates in Cities and Counties Adjacent to Newark*

Areas	1970		1974		% change between 1970-1974 rates †
	Rate	Number	Rate	Number	
Essex County	40.6	378	25.5	239	-37
Newark	77.0	295	44.2	169	-43
Irvington	21.8	13	15.3	9	-30
E. Orange	35.7	27	40.9	31	+15
Bloamfield	11.5	6	1.9	1	-84
Union County	12.7	69	12.9	71	+2
Hudson County	26.2	160	22.2	136	-15
Bergen County	9.8	888	4.5	41	-54
Passaic County	20.6	95	20.2	95	-2
Morris County	6.0	23	8.2	33	+37

* Source: New Jersey State Department of Health.

† + means increase - means decrease

parallels that of tuberculosis in some populations.^{13,14}

Blacks suffer far higher rates of both diseases than whites.^{1,20} We wondered whether the drop in tuberculosis rates might be accompanied by changes in sarcoidosis rates. The records of the four major Newark hospitals serving the majority of Newark's black population were reviewed. Table 6 shows that no clear pattern of sarcoidosis emerged during the five-year study period.

DISCUSSION

The pattern of substantial decline in rates of active tuberculosis in Newark is not unique to Newark. As shown in Table 8, between 1971 and 1974, tuberculosis rates in Jersey City, Paterson, and Trenton (the three other cities with the greatest tuberculosis problem in New Jersey) also fell substantially. The obvious question is why such a decline has occurred. We thought that there may have been discrepancies in the reduction in rates dependent on age, sex, or ethnicity. This was not found to be so. Blacks and whites,

men and women, and all age groups under 60 years shared in the decreased rates. The findings could not be explained by migration of cases from Newark to surrounding communities, since the investigation of cities and counties surrounding Newark showed no compensatory increase.

Since blacks suffer far higher rates of both tuberculosis and sarcoidosis,^{1,15} it was thought that the drop in tuberculosis rates might be accompanied by changes in sarcoidosis rates. However, the analysis of the sarcoidosis data in this study did not show any significant changes occurring in the five-year period during which the incidence of tuberculosis decreased.

The drop in tuberculosis incidence in Newark may well be related to the closing of the tuberculosis sanatorium in Essex County in 1970 and concomitant augmentation of tuberculosis clinic activities at the major hospitals, and the increased number of clinic visits at the Newark Health Department Tuberculosis Clinic. It seems likely that the augmented community-based activities resulted in increased

Table 6
Sarcoidosis Cases by Years and Hospitals
Newark, 1970-1975

Hospital	1970	1971	1972	1973	1974	1975	Total
Martland	7 (18)*	11 (28)	11 (28)	5 (13)	1 (3)	4 (10)	39
St. Michael's	5 (25)	8 (40)	2 (10)	3 (15)	2 (10)	0	20
Beth Israel	NA	26 (20)	21 (16)	34 (26)	27 (20)	24 (28)	132
United	0	0	3 (18)	4 (22)	9 (50)	2 (11)	18
Total	12 (6)	45 (22)	37 (18)	46 (22)	39 (19)	30 (14)	209

* Numbers in parenthesis are percent of total for each row

NA = Not Available.

Table 7
Rates of New Active Tuberculosis 1969-1975 in the 6 Cities of Population of Least 250,000
That had the Highest Rates in 1969

City	1969		1970 ^a		1971 ^b		1972 ^c		1973 ^d		1974 ^e		1975 ^f	
	Rate	Rank	Rate	Rank	Rate	Rank	Rate	Rank	Rate	Rank	Rate	Rank	Rate	Rank
Newark	69.2	1	52.0	5	70.0	1	69.6	1	58.0	1	44.2	5	66.3	3
Baltimore	55.1	2	54.4	2	51.1	3	48.2	3	38.5	6	54.6	2	70.6	2
Honolulu	52.4	3	52.9	3	58.2	2	57.8	2	49.9	2	63.4	1	103.2	1
El Paso	49.1	4	63.9	1	37.8	14	39.0	9	35.3	9	38.9	7	30.2	16
San Francisco	48.4	5	45.7	10	44.1	6	42.2	6	44.2	3	45.1	4	45.0	5
Washington, D. C.	47.6	6	48.9	6	43.6	7	47.3	4	41.2	4	48.5	3	53.4	4

a. Birmingham - Rank 4 (Rate 52.8)

b. Birmingham - Rank 5 (Rate 45.3); Boston Rank 4 (Rate 46.6).

c. Birmingham; Richmond - Rank 5 (Rate 44.3).

d. Sacramento; Boston - Rank 5 (Rate 38.9).

e. Tompa - Rank 6 (Rate 40.7)

f. Jersey City - Rank 6 (Rate 44.7)

Table 8
Incidence of Reported Active Tuberculosis in 4 Major Cities of New Jersey from 1971-1974*

City	1971	1972	1973	1974	% Decrease between 1971 and 1974
Newark	70.0	69.6	58.0	44.2	37
Jersey City	37.6	36.4	31.4	31.1	17
Paterson	68.3	58.5	41.3	45.8	33
Trenton	63.0	44.1	33.9	49.7	21

* Source: References 4, 7, 10 and 11

willingness on the part of newly active cases to seek early diagnosis and accept treatment. Although decentralization of tuberculosis control programs appears to us the most plausible explanation for the striking decline observed in Newark, there are alternate explanations. One possibility is that efforts by governmental and non-governmental groups to ameliorate detrimental inner-city conditions resulted in improvements in housing and/or nutrition which reduced susceptibility to tuberculosis infection. Data from Newark indicate that tuberculosis cases cluster in areas of the city characterized by rooming houses and other residences used by transients, and that hospitalized tuberculosis cases have a history of increased mobility compared to hospitalized

controls.¹⁶ These patterns could have changed in Newark between 1970 and 1974 resulting in the decreased rate of new cases of tuberculosis. Furthermore, cohort analysis of tuberculosis cases showed that reduction in tuberculosis incidence in the United States has been due mainly to a decrease in the pulmonary tuberculosis cases. Such a reduction in pulmonary cases decreases the risk of infection to others.¹⁷

In 1975, the rate of tuberculosis in Newark appeared to increase profoundly (Table 7). This, however, represents an entirely new reporting system.¹⁸ This change in reporting practice, started in 1975, requires additional longitudinal surveillance in order to ascertain future tuberculosis trends.

SUMMARY

For several years Newark ranked number one in tuberculosis incidence among 58 major cities with a population of 250,000 or more in the United States. In 1974 the rates fell substantially. The obvious question is why this has occurred.

Two years, 1970 and 1974, were selected for analysis of tuberculosis incidence among Newark residents. The demographic information for each case was collected from the New Jersey State Department of Health and from records of hospitals, clinics, and private physicians' offices.

Three hundred and seventy four, and 264 new tuberculosis cases were reported in 1970 and 1974 respectively. Data on 94 percent of these were obtained.

The rate of active tuberculosis in Newark decreased 29 percent from 1970-1974. We questioned whether the reduction in tuberculosis rates may have been dependent upon age, sex, race, or migration. This was found not to be so. Blacks and whites, men and women, and all age groups under 60 years shared in the decreased rates. Investigation of cities and counties surrounding Newark showed no compensatory increase. Also, the analysis of the sarcoidosis data did not show any clear incidence pattern.

Furthermore, the studies on cohort and cross-sectional analysis of tuberculosis showed that reduction in tuberculosis incidence has been due mainly to a decrease in the pulmonary tuberculosis cases. Such a reduction decreases the risk of infection to others.

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Basilar Artery Thrombosis after Closed Head Trauma: Case Report with Angiographic Correlation

EDWIN S. WILSON, M.D. AND
HAROLD W. RUSHTON, M.D., Mount Holly*

A patient is reported who expired due to basilar artery thrombosis after blunt trauma to the head. The antemortem diagnosis was established by cerebral angiography and confirmed at postmortem examination. Post-traumatic basilar artery thrombosis is rare and is associated with a high mortality rate. Precise angiographic diagnosis may enhance the neurosurgical or non-operative management of such patients.

Cranial and/or cervical injury is seen more frequently in the acute care general hospital, due to the increasing number of high-speed vehicular accidents. Precise anatomical diagnosis of such traumatized patients is necessary so that the appropriate neurosurgical approach may be selected. Cerebral angiography provides a reasonably safe method to obtain this information.¹ The use of catheter cerebral angiography via the femoral or brachial artery also allows the angiographer the flexibility of examining other traumatized organs remote from the head by appropriate catheter placement at the same sitting, if necessary.

Post-traumatic thrombosis of the internal carotid artery or its branches is a well-recognized complication following nonpenetrating head and/or cervical trauma.² Thrombosis of the basilar artery has been reported after clivus fracture, but very few cases have been reported following blunt trauma without fracture.^{3,4} This report cites a patient with basilar artery thrombosis without clivus fracture, following blunt trauma to the head. Although the patient eventually succumbed, the diagnosis was established by cerebral angiography prior to his demise.

CASE REPORT

A 21-year-old male was admitted to the hospital from the emergency room following blunt trauma to the head in an automobile accident. The patient, a passenger seated beside the driver, struck the frontal region of his head against

the dashboard. When first examined in the emergency room, the patient was responsive and had no focal neurological deficit. It was noted, however, that his eye movements were slightly uncoordinated; motion of the right eye was somewhat slower than the left. He complained of nausea and appeared lethargic. He was admitted to the hospital for observation with the tentative diagnosis of cerebral contusion. Blood pressure on admission was 100/70 mm. Hg. and the pulse was 104 per minute.

Shortly after admission, the patient became unresponsive with left facial paralysis, external ophthalmoplegia of the right eye, and downward gaze of the left eye with rotary nystagmus. The pupils were both markedly constricted. He subsequently developed left hemiparesis, bilateral Babinski reflexes, and hyperpyrexia. Because of respiratory distress, a tracheostomy was performed. Emergency cerebral angiography by brachiocephalic injection visualized both the carotid and vertebral arteries. The right carotid artery was normal. Contrast medium filled the right posterior cerebral artery by means of the right posterior communicating artery, and demonstrated a linear radiolucent filling defect within the proximal segment of the right posterior cerebral artery. (Figures 1 and 2). However, there was filling of only the

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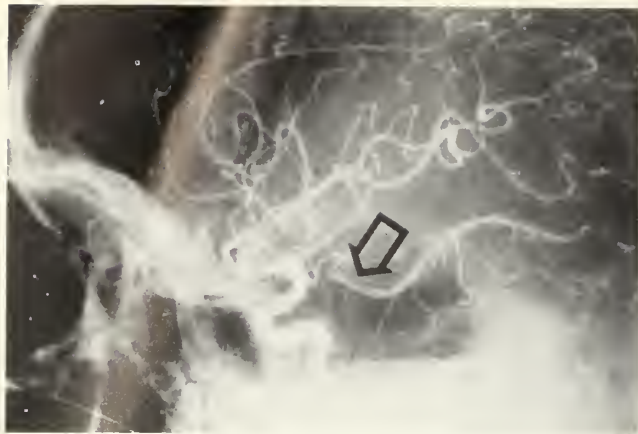


Figure 1—Lateral projection of the right cerebral arteriogram. There is a radiolucent filling defect (arrow) in the proximal segment of the right posterior cerebral artery.

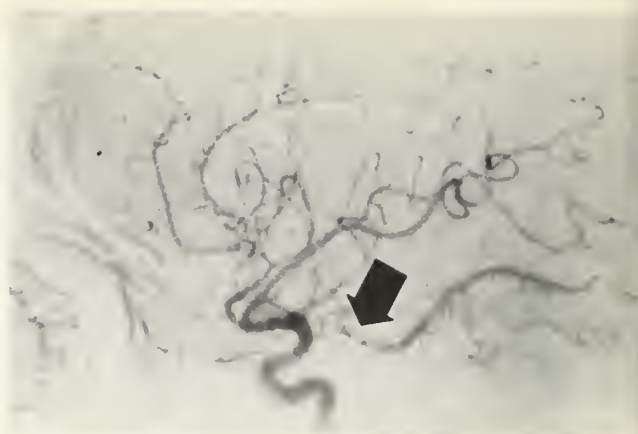


Figure 2—Subtraction film of the same projection details the thrombus outlined proximally and distally by contrast medium.

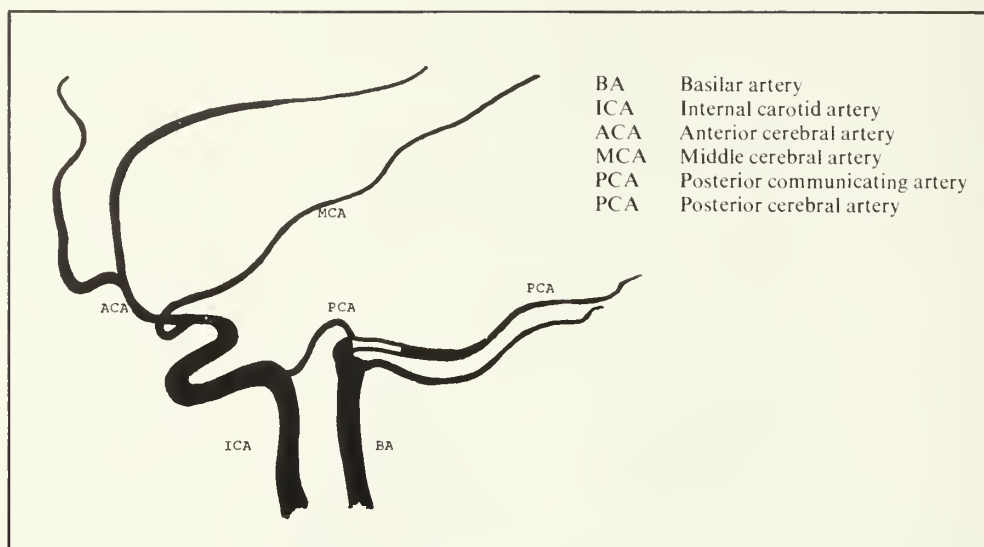


Figure 3—Line drawing corresponding to the lateral carotid arteriogram. The occluded basilar artery has been redrawn and added to the figure.

proximal segment of the right vertebral artery suggesting spasm and/or obstruction. Left carotid arteriography was normal. Selective vertebral arteriography was not attempted.

Over the next 24 hours the patient developed respiratory failure requiring assisted ventilation by a respirator. The diagnosis of brain stem infarction due to basilar artery thrombosis was established by angiography. The patient remained in coma, became hypotensive, and finally expired 48 hours after admission to the hospital.

Postmortem examination revealed multiple contusions and edema of the forehead and face. The major pathology consisted of softening of the occipital lobes and marked congestion of the pons, medulla, and cerebellum. There was no fracture. The basilar artery and the proximal segment of the right posterior cerebral artery were occluded by thrombus, which was firmly adherent to the blood vessel wall. The basilar artery was compressed between the clivus and the edematous brain stem, and the arterial wall appeared contused. The anterior aspect of the pons and medulla was ecchymotic. The final pathological diagnosis was brain stem infarction and encephalomalacia due to vascular contusion and thrombosis of the basilar and right posterior cerebral arteries.

DISCUSSION

Complex post-traumatic cerebral and brain-stem injuries are becoming more frequent in clinical practice. As the clinical parameters often are non-specific, cerebral angiography offers precise anatomical diagnosis separating lesions which require emergency surgical intervention from those which require more conservative management. True complications of cerebral angiography have been estimated between 0.2 and 4.5 per cent.⁵ The specific method of cerebral angiography should be selected for the individual patient and the clinical circumstances. An advantage of catheter cerebral angiography is the opportunity to study multiple vessels after one arterial puncture. Direct needle puncture carotid and/or vertebral angiography often is more difficult than catheter cerebral angiography. Furthermore, catheter angiography allows the examination of other vessels (abdominal or thoracic) if required in the patient with multiple traumatized segments of the body. Computerized tomography of the brain allows rapid and accurate diagnostic evaluation of the patient with suspected subdural and/or intracerebral hematoma. Unfortunately, this newer revolutionary diagnostic tool (computerized axial tomography) is not universally available to all patients at present; it soon should be available to most

medium to large-sized community hospitals.

Occlusion of the basilar artery with brain stem infarction is a rare occurrence after trauma.^{6,7} Basilar artery thrombosis has been reported following clivus fracture, due to entrapment of the artery within a diastatic fracture during the moment of impact. Loop *et al.*, in 1964, reported the first case of post-traumatic basilar thrombosis in which the diagnosis was established by angiography.³ Few cases have surfaced in the literature since that report, and those which have been reported were recognized at postmortem examination rather than prior to the demise of the patient.⁴

The absolute radiographic diagnosis of basilar thrombosis by angiography depends upon the demonstration of a radiolucent filling defect within the vessel. The presence of blood within the subarachnoid space may be sufficient to produce spasm of the basilar and/or vertebral arteries, and simple non-filling of the artery is not sufficient to establish the diagnosis unequivocally. Flow phenomena can be excluded by the opacification of both vertebral arteries by selective vertebral angiography. With adequate filling of the basilar and vertebral arteries by contrast medium, the presence of a sharply margined radiolucent filling defect is diagnostic.

The patient here reported lapsed into coma after a short lucid interval following blunt trauma to the head. No fracture was demonstrated on routine skull examination. Emergency cerebral angiography was performed, and demonstrated non-opacification of the basilar artery and the presence of a radiolucent filling defect within the right posterior cerebral artery, which filled by means of the posterior communicating artery during right carotid angiography. Based on these findings, the diagnosis of basilar and right posterior cerebral artery thrombosis was made. Selective vertebral angiography was felt to be redundant, as well as potentially hazardous in view of the patient's dire clinical status. The angiographic diagnosis was confirmed at autopsy.

The apparent mechanism of injury in this patient was rapid deceleration by concomitant blunt trauma of the frontal

region of the skull, with resultant hyperflexion of the cervical spine. No fracture could be demonstrated clinically, radiographically, or by postmortem examination. The basilar artery thrombosis apparently was caused by compression of the basilar artery between the clivus and brain stem, with subsequent contusion, subintimal laceration, and thrombosis. Thrombosis may have been accentuated by the basilar and/or vertebral spasm and vascular stasis induced by subarachnoid hemorrhage.

SUMMARY

The clinical syndrome of brain stem infarction due to basilar thrombosis is almost invariably fatal.^{3,4,7} Despite this high mortality, we believe that angiography is indicated to establish the correct diagnosis without equivocation, and to exclude such potentially surgically curable lesions as subdural and epidural hematoma. The clinical spectrum between these entities is not clearly distinguishable. Angiography provides the mechanism for precise anatomical diagnosis allowing the clinician to deliver the most appropriate neurosurgical or non-operative management to these patients.

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Hemoptysis in Pulmonary Cryptococcosis

DAVID J. RILEY, M.D. AND
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Persistent, severe hemoptysis was the initial symptom of pulmonary cryptococcosis in a previously healthy man. Although blood-tinged sputum occasionally may be seen in pulmonary cryptococcosis, severe hemoptysis as the presenting feature of this disorder appears to be unique.

Pulmonary cryptococcosis may present as an asymptomatic pulmonary nodule or as a progressive infection of the lung. Severe hemoptysis as the initial symptom of this disease has not been reported. We report here a case of pulmonary cryptococcosis in which persistent hemoptysis was the major clinical feature, and review the literature to determine how often hemoptysis is associated with pulmonary cryptococcosis.

CASE REPORT

A 51-year-old male was hospitalized in 1975 for hemoptysis. Five weeks previously he developed mild anterior chest pain and a cough productive of two to three cupsful per day of bright red blood. There were no systemic symptoms and he denied contact with pigeons. A chest roentgenogram showed a nodular density in the lateral left mid-lung field. Cytologic examination of the sputum disclosed no tumor cells; a culture showed no growth of micro-organisms. A needle-aspiration-biopsy of the lesion was non-diagnostic. He was discharged after two weeks and continued to cough up 30 to 50 ml. of bright red blood per day; he was readmitted for further evaluation.

On examination, the temperature was 37.7° C, the pulse 80, respiration 20, and the blood pressure was 190/90 mm Hg. The neck was supple. Coarse rales were audible over the base of the left lung. The examination was otherwise normal. The hematocrit was 40 per cent; the white cell count

was 7,300 cells per ml, with a normal differential count; the erythrocyte sedimentation rate was 10 mm per hour. A chest roentgenogram showed no change in the nodular density in the left lateral mid-lung field (Figure 1). A skin test for mumps was positive; a tuberculin skin test (PPD, 5 T.U.), skin tests with atypical mycobacteria (B and Y), histoplasmin, and coccidioidin were negative. A pulmonary angiogram was done to exclude recurrent pulmonary emboli and was normal. Bronchoscopic examination revealed a large amount of blood coming from the left lower lobe bronchus; no intrinsic lesion or compression was seen. A stained specimen of the bronchial washings and cultures was negative; cytologic examination showed no tumor cells. A lumbar puncture yielded clear, colorless cerebrospinal fluid that contained two lymphocytes and one neutrophil per ml.; the glucose was 72 mg/dl and the protein 30 mg/dl; no organisms were seen on India ink preparation, and the culture was negative.

At thoracotomy, several one to two cm. lesions were palpable near the surface of left posterior basal segment. Microscopic examination revealed granulomas containing predominately histiocytes, a few multinucleate giant cells, and a border of aggregates of lymphocytes; there was no necrosis or caseation. In sections stained with hematoxylin-eosin, abundant yeast-like organisms were visible which

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Figure 1—Chest roentgenogram showing homogeneous density in periphery of mid-zone of left lung.

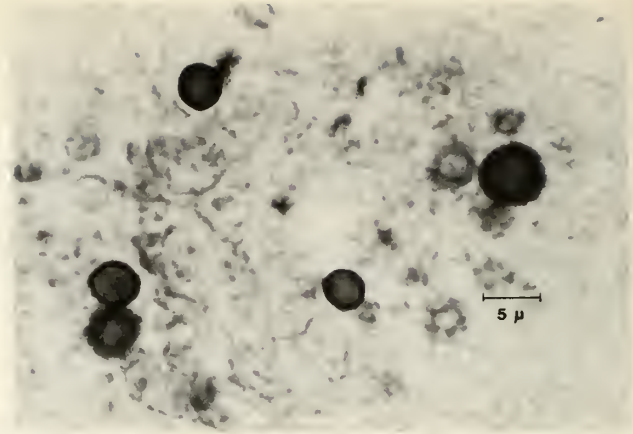


Figure 2—Photomicrograph of lung tissue showing yeast forms identified as *Cryptococcus* (Gridley stain, x 1000).

appeared as pale blue, thin-walled, spherical bodies (Figure 2). The fungi contained no internal structure, and no mycelia were identified; a few budding forms were seen. With mucicarmine stain, a thin carminophilic zone surrounded the fungal forms, a feature consistent with *Cryptococcus* organisms. Culture of the tissue grew *Cryptococcus neoformans*.

The hemoptysis ceased after surgery, and further evaluation showed that the infection was confined only to the lungs. He was well two years later.

DISCUSSION

Cryptococcus neoformans enters the respiratory tract and causes either no symptoms or an illness which is indistinguishable from an upper respiratory tract infection. From the lungs, the organism may disseminate widely and involve the meninges, bones, or skin. In some instances, especially in a compromised host, the primary lung infection may progress and cause cough, production of mucoid sputum, fever, chest pain, weight loss, and malaise. The chest roentgenogram usually shows one or more areas of patchy parenchymal infiltrate. The organism frequently is not recovered from the sputum, and diagnostic skin tests have not been developed. The disease may be suspected if the patient has been exposed to pigeons or if meningeal involvement is present. Serum titers for cryptococcal antigens are usually positive in cryptococcal meningitis but are usually negative in the pulmonary disease.¹ Most patients whose lesions are removed surgically have complete resolu-

tion of the pulmonary disease, and the risk of developing cryptococcal meningitis is low;² however, all patients should be followed carefully for the development of meningitis.

Hemoptysis as the presenting feature of pulmonary cryptococcosis is unusual. We reviewed 227 cases of pulmonary cryptococcosis reported in the English literature since 1924 and found 29 in which hemoptysis was reported,³⁻²⁰ an incidence of 12.8 percent. In those cases in which the severity of bleeding was mentioned, the sputum was usually spotted or streaked with blood, and in no case was hemoptysis massive. In none was bleeding the initial symptom. Seven of the 29 cases had coexistent tuberculosis which could have been an alternative cause of bleeding. There seemed to be no correlation between the severity of disease on chest x-ray or the presence of cavities and the occurrence of hemoptysis in these 29 cases, compared to those without hemoptysis.

Thus the presently reported case of severe persistent hemoptysis as the only presenting symptom in a patient with pulmonary cryptococcosis, who had no other discernable disease, appears to be unique.

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Echocardiography in the Diagnosis of Pericardial Effusion*

JACK J. KLEID, M.D., Bronx, New York**

The purpose of this item is to demonstrate to the practicing physician the variety of techniques available to establish a clinical diagnosis in cardiology without the need for the more elaborate and potentially hazardous invasive techniques.

A 32-year-old male lawyer presented to his physician with fever, tachycardia, shortness of breath, and pleuritic chest pain. Physical examination revealed what appeared to be a pericardial friction rub. The patient was hospitalized immediately. An electrocardiogram demonstrated precordial T wave inversions and a chest x-ray showed moderate cardiomegaly. The diagnosis of acute pericarditis with effusion was entertained.

To confirm this presumptive diagnosis an ultrasonogram of the heart was performed (Figure 1). This relatively simple non-invasive technique corroborated the diagnosis of pericardial effusion. Note that in figure 1, which is a sweep from the mitral valve (MV) to the aorta (AO), there is a moderate-

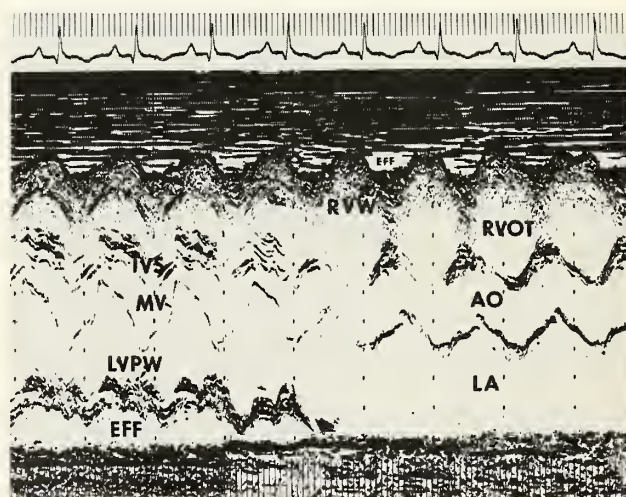


Figure 1—Echocardiogram demonstrating pericardial effusion (EFF), anterior to the right ventricular wall (RVW) and also behind the left ventricular posterior wall (LVPW). The posterior space is seen to disappear as the transducer is angulated toward the base of the heart (arrowhead). MV = mitral valve, IVS = intraventricular septum, LA = left atrium, AO = aorta, RVOT = right ventricular outflow tract, RVW = right ventricular wall.

*Edited by Sidney R. Arbeit, M.D., Jersey City, and Ira L. Rubin, M.D., New York. Dr. Arbeit is Associate Clinical Professor of Medicine, New Jersey Medical College, CMDNJ; attending physician and emeritus chief, division of cardiovascular diseases, Jersey City Medical Center; attending physician and chief of cardiology, Jewish Hospital, Jersey City; associate attending physician, division of cardiology, Montefiore Medical Center, Bronx, New York. Dr. Rubin is Clinical Professor of Medicine, Einstein College of Medicine, New York; attending physician, division of cardiology, and chief of electrocardiographic service, Montefiore Medical Center, Bronx, New York.

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sized sonolucent zone (echo-free-space) (EFF) behind or posterior to the left ventricular posterior wall (LVPW). This space is seen to disappear as the ultrasonic transducer is angulated toward the left atrium (LA). This echo-free space represents fluid in the pericardial sac. Fluid, because its

density is lower than solid cardiac structures appears on the echogram as a sonolucent zone. Usually pericardial fluid does not accumulate behind the left atrium as in this case. The sonolucent zone disappears at the level of the left atrium. If figure 1 is compared to figure 2 (a patient without effusion) it is quite obvious that the latter lacks an echo-free space behind the posterior wall of the left ventricle (LVPW).

Cardiac ultrasonography presently is a well-established and sensitive technique for making the diagnosis of pericardial effusion.^{1,2} Prior to the advent and practice of echocardiography, invasive means such as CO₂ injections, right heart catheterization and angiography were commonly utilized to establish this diagnosis. The non-invasive atraumatic cardiac echogram performed in the case presented was a quick and relatively simple approach in diagnosing effusion. No untoward effects have been reported thus far with the use of cardiac ultrasonic techniques.

This patient was placed on prednisone and followed by serial echocardiograms. In a matter of a few days he became asymptomatic and his pre-discharge echogram showed no evidence of pericardial effusion.

REFERENCES

1. Feigenbaum H: *Echocardiography*. Philadelphia, Lea and Febiger, 1972, pp. 163-186.

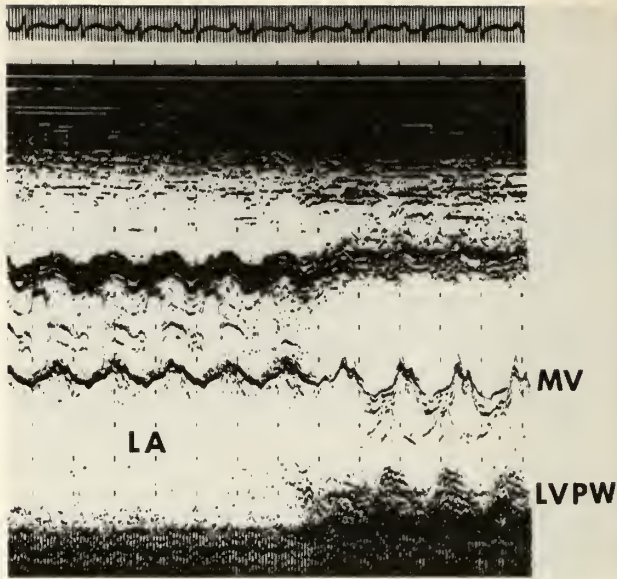


Figure 2 — Echocardiogram in a patient without pericardial effusion. MV = mitral valve, LA = left atrium, LVPW = left ventricular posterior wall.

2. Kleid JJ and Arvan S: *Echocardiography: Interpretation and Diagnosis*. New York, Appleton-Century-Crofts, 1978, pp 186-209.

Selected Abstracts with Comments*

Radiologic Appearance of Viral Disease of the Lower Respiratory Tract in Infants and Children. Osborne D—*Am J Roent* 130:29 (1978).

One hundred twenty-eight proved (culture plus serology) pneumonias due to viruses were studied. Respiratory syncytial virus was etiologic in 65, adenovirus in 18, parainfluenza in 26, and influenza and measles in the rest. Patchy pneumonia (lobular or subsegmental atelectasis) was seen in 72 and larger consolidation was seen in 20. In 107 interstitial involvement existed as well or alone. Airtrapping was seen in half of the patients most commonly with RSV. Adenovirus had the most extensive changes and was slower to resolve. Pleural effusion was seen in only two patients (one adeno, one parafflu).

Comment: The etiologic diagnosis of pneumonia in children is difficult. Isolation of a bacterium on lung puncture or transtracheal aspiration is diagnostic but these procedures are done rarely. Blood culture when positive is diagnostic. Viral diagnosis requires the isolation of a virus plus a serologic response to that virus (or at least the latter). These carefully studied patients had viral disease that appeared uncomplicated yet the x-rays easily could be called classic for bacterial pneumonia (lobular and lobar disease in some).

Most pediatricians understand that they cannot be sure and, therefore, usually treat such children as if they had bacterial pneumonia. However, when such patients have a clearly defined syndrome (bronchiolitis or acute laryngotracheobronchitis), the association of some alveolar or interstitial pathology should not call automatically for antimicrobials. (R. Rapkin, M.D.)

Quality Assessment of a Telephone Care System Utilizing Non-Physician Personnel. Katz H P, *et al.*—*Am J Publ Hlth* 68:31 (1978).

Health assistants using protocols provided telephone advice to parents. Triage preceded the advice (also according to protocol) and some patients were asked to come in. Follow-up was carefully done on over 2000 encounters. Ninety percent of parents were satisfied and 92 percent of problems had resolved on seven day follow-up. Seventy-five percent of all calls were managed by the health assistants without referral.

Comment: If you are upset by these findings please read the article. This was a most carefully done and well controlled study. We are not indispensable. Our patients can get

along without us if we are careful and thorough. Using non-nurse, non-physician personnel (average age 42, mother of 2.3 children, employed for 2.9 years, high school graduate) these pediatricians demonstrated rigorously good care and additional time for more complex problems. Why not?

(R. Rapkin, M.D.)

Early Nutrition: Its Long-Term Role. Filer L J—*Hosp Practice*: Feb. 1978, p. 87.

This review article in the "best throwaway" merits careful reading. Dr. Filer makes the following points:

a. Human milk is best as *sole* source of nutrition from 0-6 months and as a primary source from 6-12 months.

b. Cow milk (unmodified) often causes intestinal blood loss and should be withheld during first year of life.

c. Solids need not be introduced before 6 months.

d. Obesity in infancy is usually the result of overfeeding. The breast-fed baby stops when he is full. The bottle-fed baby is often encouraged to finish the bottle.

e. Obesity is best diagnosed using calipers to measure skinfold thickness.

f. Skim milk, rather than just preventing obesity, may lead to malnutrition because the infant cannot ingest enough energy to meet nutritional requirements (even if supplemented with solids). Skim milk has no place in an infant's diet during the first year.

Comment: Convincing data support all the conclusions reached. Traditional practices need to be reassessed constantly. (R. Rapkin, M.D.)

The Evolution of Specific Genetic and Environmental Counseling in Congenital Heart Diseases. Nora J J and Nora A H—*Circulation* 57:205 (1978).

Comment: This extensive review, excerpted from a forthcoming book by two of the most knowledgeable experts in this field, is a *must* for anyone who must answer the most frequent questions about future children from parents who have had a baby with congenital heart disease. It is chock-full of specific information about specific defects, presented largely in tabular form. It is becoming clear that genetic

*Abstracted from "Pediatric Department Newsletter," RMS, Vol. 2, No. 6 (Feb. 1978). Selections are made and original comments prepared by Richard H. Rapkin, M.D., Professor of Pediatrics, RMS CMDNJ, and his associates.

influences are more important in predisposing to C.H.D. than we thought in the past; this article documents the evidence while wisely pointing out the difficulties of interpreting statistics for any individual family. (N. Sissman, M.D.)

Streptomycin and Sulfisoxazole for Treatment of *H. Influenzae* Meningitis. Meade R H—*JAMA* 239:324 (1978).

Sixty-one children treated with ampicillin were compared with 50 children who received streptomycin (IM and intrathecal) and sulfisoxazole (IV and po). There were no differences in success.

Comment: This study confirms previous data that this combination is as effective as any. Another alternative to ampicillin (in *H. flu* resistance) is demonstrated.

(R. Rapkin, M.D.)

The Expediency of Peritoneal Lavage for Blunt Trauma in Children. Drew R, *et al*—*Surg Gyn Obstet* 145:885 (1977).

Diagnostic peritoneal lavage was 99 percent accurate in determining presence or absence of intra-abdominal injuries in 230 children. There was only one false negative.

Comment: Confirmation of this excellent procedure (insertion of a dialysis catheter midline with lavage with 15 ml/kg of Ringer's lactate and recovery of fluid—fluid is analyzed for blood—RBC > 100,000/ml is positive) is provided by this article. The current question is if the patient has a ruptured spleen what then. Many surgeons are attempting to preserve this immunologically important organ by repair. One group recently advocated nonsurgical support with transfusions and showed spontaneous healing in several patients! Another tradition may be being destroyed.

(R. Rapkin, M.D.)

Principles of Concomitant Antibiotic Therapy. Weinstein A J—*Med J Australia* October 8, 1977 supplement p. 19.

Combined use of antibiotics can be synergistic, indifferent, or antagonistic. Antagonism is obviously a disadvantage. Other disadvantages are increased toxicity, expense, superinfection (destruction of normal flora with subsequent colonization and infection by new resistant flora) and, perhaps most important, a "false sense of security" which may

lead to the cessation of diagnostic efforts because "everything is covered." However, there are indications: synergism, prevention of development of resistance, treatment of mixed infections, and initial treatment of severe infections.

Comment: An exhaustive list of examples cannot be noted here. The principle is that combined therapy (more than one antibiotic) should have a specific defensible reason. Blind "broad coverage" is the commonest error in the treatment of infectious disease.

Rubella Infection and Diabetes Mellitus. Meuser MA, *et al*—*Lancet* 1:57 (1978).

Fifty children with congenital rubella diagnosed by Gregg (Australia) in 1941 were followed. Forty-five were found and nine had diabetes mellitus. Congenital rubella infection in rabbits caused histologic changes in B cells of the islets. Diabetes in congenital rubella may be due to viral infection of pancreatic islets.

Comment: The authors state: "We do not think that the congenitally acquired rubella virus is responsible for a large number of cases of diabetes in man . . . there may be other viruses that initiate the diabetic process and contribute to the overall incidence of this disease." What percentage of diabetics have their disease caused by virus is unknown. However, this unequivocal demonstration of congenital virus infection and diabetes is intriguing!

Multiphasic Screening in General Practice. Editorial, *Lancet* 1:29 (1978).

Patients aged 40-64 were screened or not. A health survey done five years later revealed no differences in morbidity or mortality in screened vs nonscreened group. The costs of screening were very high. Conclusions were ". . . screening in the middle age can no longer be advocated . . . as a desirable public health measure . . . we must conclude that regular health checkups do not guarantee a longer life or a better one. . .".

Comment: Specific screening (e.g. Pap smear, breast exam, blood pressure, etc.) probably is different than the full scale general screening done here. The costs of directed screening are less. The results more easily seen. (R. Rapkin, M.D.)

DOCTOR'S NOTEBOOK

Trustees' Minutes

Two regular meetings of the Board of Trustees were held during the 1978 annual meeting in Atlantic City. Detailed minutes are on file with the secretary of your county medical society. A summary of significant actions follows:

May 5, 1978

C. Byron Blaisdell, M.D. . . . Stood for a moment of silent prayer in tribute to the memory of C. Byron Blaisdell, M.D., former chairman of the Board of Trustees and AMA Delegate, who died on April 20, 1978.

. . . Authorized the customary donation to the Medical Student Loan Fund in Dr. Blaisdell's memory.

Chiropractic Suit vs. Radiological Society
. . . Received a report from the Executive Director that Dover General Hospital will make available to chiropractors the use of the outpatient radiological service by reason of a settlement of this portion of the above-named suit via a consent judgment. The Executive Officer will analyze the consent judgment and report further to the Board.

Seminar on Impaired Physicians . . . Authorized the attendance (with expenses paid) of two members of the Committee on Impaired Physicians at the seminar on that subject to be held in Minneapolis, September 29 through October 1.

CMDNJ . . . Received the following report from the College of Medicine and Dentistry:

1. Middlesex General Hospital—CMDNJ Affiliation—Progress: On April 28, the State Health-Planning and Coordinating Council voted to recommend approval of the Certificate of Need request for Middlesex General Hospital renovation and reconstruction project. This will provide at MGH the appropriate base as a core teaching

hospital for the CMDNJ-Rutgers Medical School. Although various stipulations were added, they seem reasonable and attainable.

2. CMDNJ-Rutgers Medical School Proposed Name Change: At its March meeting, the State Board of Higher Education voted to suggest that the CMDNJ Board of Trustees consider a change in name for the CMDNJ-Rutgers Medical School in Piscataway—an apparent effort to eliminate what some believed was confusion over the medical school's affiliation. The CMDNJ Board, however, at its April meeting voted unanimously to reject the suggestion; Board Chairman Kittredge joined me in a message to the entire College community noting that "the strength of our College rests in part upon the diversity of programs and the differing character and emphases of our three medical schools."

3. College Hospital Multidisciplinary Cancer and Research Facility: In April, the Board of Trustees of the Regional Health Planning Council (HSA II) recommended approval of the CMDNJ request for certificate of need for construction of a \$2.6 million cancer research and care facility adjacent to and part of the new College Hospital. The center would include a 20 MEV linear accelerator, although the approval excluded purchase of a CAT scanner, hence effecting savings of some \$1 million. The request now goes to the State Health Planning and Coordinating Council for final recommendation to the Commissioner of Health.

4. New Dean, New Vice President: Edward J. Cafruny, M.D., Ph.D., has accepted the post of Dean of the CMDNJ-Graduate School of Biomedical Sciences and will begin his tenure in July. Mr. Eugene M. Galligan joined CMDNJ last month as Vice President for Planning and Development. Dr. Cafruny comes to the College from the Medical College of Wisconsin, where he has been professor of pharmacology;

previously he served terms as professor of pharmacology at Cornell University Medical College and as president of the Sterling-Winthrop Research Institute and senior scientist at the parent Sterling Drug, Inc. Mr. Galligan most recently worked with the City of Philadelphia Department of Health, Philadelphia General Hospital and the City of Philadelphia Nursing Home to establish a model for planning and implementation of the conversion of Philadelphia General Hospital from an acute-care to an intermediate-care facility. Earlier he was vice president for operations of the Health Corporation of America in Wayne, Pennsylvania, and held extensive additional administrative positions including coordinator of educational services for Duquesne University as well as assistant professor of management at its School of Business Administration.

5. Commencement Speaker: Samuel D. Proctor, Th.D., noted educator, theologian and civil rights leader, will give the CMDNJ commencement address at the Garden State Arts Center in Holmdel on June 2. Dr. Proctor is professor of education at Rutgers, the State University, and senior minister of the Abyssinian Baptist Church in New York. His academic career has included both teaching and administration, including terms as president of Virginia Union University and North Carolina A&T University; he has served in administrative capacities with the Peace Corps in Nigeria and Washington, the National Council of Churches, the Office of Economic Opportunity, and the Institute for Services to Education.

The College will award 180 M.D. degrees this year, 55 D.M.D. degrees, eleven Ph.D.s and 71 certificates of completion of training in the allied-health professions.

6. Medical School Admissions: The College admissions offices have taken pains to disassociate CMDNJ from allegations unveiled last month in a *New York Times* survey report con-

cerning the buying and political distribution of places in United States medical schools. CMDNJ-New Jersey Medical School admissions director emphasized that his school has "developed a foolproof, open, pressure-proof system . . . whereby (admissions) decisions are made by 15 to 20 faculty members and students whose vote is tabulated, and a priority list of acceptable candidates maintained for every member to check and monitor. This list is absolutely inviolable; no one can change the position of a candidate on that list. Candidates are awarded acceptances from the top of that list—only from the top of that list—and in the order determined by the collective vote of the admissions committee." Regardless of injustice alleged elsewhere, admissions to all CMDNJ schools are made on the basis of competitive evaluation alone.

7. Middle-Level Health Practitioners: CMDNJ will invite physicians, hospital administrators and directors of hospital medical education to participate, along with state legislators and key figures from the insurance and drug industry and the Board of Medical Examiners, in a conference all day Thursday, June 1, to assess and promote the use of middle-level health practitioners—physicians' assistants, nurse clinicians and nurse midwives—as a means of improving health-care delivery through providing another source of health manpower. The discussions will consider the impact of such personnel on health-care delivery, on health manpower problems, and on cost containment. Noted health economists, health educators, and federal administrators will participate.

8. Sports Medicine Symposium: A hundred or more physicians and others stimulated by the nationwide boom in recreational sports are expected at the first sports-medicine symposium formally presented for credit through the College's Office of Continuing Education, all day Wednesday, May 17, at the Medical Sciences Building on the Newark campus. Sponsored jointly with the CMDNJ-New Jersey Medical School's new Division of Sports Medicine, within the surgery department's orthopedics section, the program will feature panels and talks on running, swimming, skiing, and the dance, along with attention to psychological factors and training/conditioning.

The following is a summary of actions

taken at the CMDNJ Board of Trustees' April meeting.

1. Suggested Name Change for CMDNJ-RMS: The Board voted unanimously to reject the resolution passed by the New Jersey State Board of Higher Education which suggested to the CMDNJ Trustees that they consider a different name for the CMDNJ-Rutgers Medical School.

2. Advisory Council on Graduate Medical Education: The Board approved the request to finance the operation of the Advisory Council on Graduate Medical Education through the use of FY78, escrow funds in the amount of \$341,750.

3. Design Work: The Board approved, subject to the availability of funds, the request to DBC to engage architects, at a cost not to exceed \$10,600 to do the design work for the radiology alterations and the construction of a heliport.

4. Dental School Level B: The Board approved the expenditures of funds not to exceed \$12,000 for a feasibility study for developing alternatives for utilization of Dental School Level space.

5. CMDNJ-NJMS-CMHC: The Board authorized the replacement of the multipurpose room floor of the CMDNJ-NJMS Community Mental Health Center at a cost not to exceed \$15,000.

6. CMDNJ-Raritan Valley Hospital: The Board authorized the repair and sealing of structural concrete for the Raritan Valley Hospital addition within a cost not to exceed \$9,000.

7. Outside Office: The Board approved an outside office for Dr. Marshall Swartzburg of the CMDNJ-Rutgers Medical School.

8. Psychiatric Beds: President Bergen reported that the College has received a Certificate of Need for the 33-bed psychiatric unit to be built on top of the Community Mental Health Center in Newark.

9. Education Building: President Bergen reported that the Department of Higher Education has given its approval to proceed with the construction of the Medical Education Building adjacent to the Middlesex General Hospital in New Brunswick.

10. Linear Accelerator: President Bergen reported that the Area II Review

Committee, on April approved the Linear Accelerator for the new College Hospital. It will now be reviewed by State Health Planning Council for a Certificate of Need.

11. Saudi Arabian Program: The Board authorized the acceptance of thirty students from the Medical School of Jeddah, Saudi Arabia under the provisions laid down by the Administration. The thirty students, two groups of fifteen each, will spend two weeks each at the CMDNJ-New Jersey Medical School observing our hospitals, our problems in medicine and patterns of medical care. This program is exclusively observational and a learning experience through seminars, lectures and case histories.

12. Essex County Medical Society Resolution: The Board received and considered a resolution from the Essex County Medical Society of New Jersey to petition the CMDNJ Board of Trustees to establish a Department of Family Practice at the CMDNJ-NJMS. It was the consensus of the Board that this resolution be passed on to the faculty for their information and consideration.

13. RVH Auxiliary Bylaws: The Board approved the proposed Constitution and Bylaws for the Auxiliary of Raritan Valley Hospital.

14. Gerontology in Medical Education Program: The Board authorized President Bergen to sign a grant agreement with the County of Essex Department of Aging whereby they will grant for the period of January 1, 1978, through December 31, 1978 a maximum of \$24,450 to support the Gerontology in Medical Education Program.

Maternal and Infant Welfare . . . Received a report from the Committee on Maternal and Infant Welfare concerning a referral from the Board on the "Proposed Rules on Principal Midwife" under the Standards of Practice for Nurse-Midwives. The Committee report made the following points: (1) no definite need for nurse-midwives in New Jersey has been established, (2) the State Board of Medical Examiners' proposed regulation for nurse-midwives is restrictive and the services already are being performed by registered obstetrical nurses, (3) does the rule (section 13:35-9.6 (a)) regarding anesthesia restrict nurse-midwives from administering anesthesia and will nurse anesthe-

tists, who have been administering general anesthesia, be allowed to continue to do this?, (4) section 13:35-9.6 (a) 7 which concerns performance of episiotomies and repair of extended perineal, vaginal, or cervical lacerations, should be separated into two sections—episiotomies should be performed by a physician, (5) do the functions listed for the nurse-midwife preclude the registered obstetrical nurse from performing these services under the direct supervision of the attending physician?

Standard Claim Forms . . . Received a report from the Committee on the Acceptance of Standard Claim Forms which indicated that Blue Shield's position is that it cannot accept a standard claim form at this time. It was noted that the AMA has adopted a Uniform Claim Form which is being used by private insurance companies, Medicare, Medicaid, and many Blue Shield organizations throughout the United States, and the Committee believes there is no legal or technical reason to prevent adoption and utilization of this standard by Blue Shield of New Jersey.

Disputed MSP and HSP Claims . . . Received a report from the Vice-President of MSP which advised the Board that the Hospital Association has been dissatisfied with some of the decisions rendered in MSP and HSP disputed claims that had not been reviewed by the entire Advisory Committee. Communication will come from the Hospital Association concerning expansion of MSNJ representatives on the Advisory Committee to Review MSP and HSP Disputed Claims.

New Jersey Hospital Association . . . Accepted the resignation of Rudolph C. Gering, M.D., as MSNJ's representative to the Board of Trustees of the New Jersey Hospital Association.

State Board of Medical Examiners . . . Received as informative a communication from the Board of Medical Examiners which stated that the Board had rescinded its resolution of December 14 terminating all exemptions of non-licensed physicians as of June 1978. The State Board reiterated its concern that there should not exist two standards of care—one for private patients and one for institutional patients (where some non-licensed physicians were employed)—but that the action contemplated is accomplished more appropriately under the Administrative Procedure Act and

will be proposed as a rule.

Retiring Members . . . Expressed appreciation for their services to retiring Board members Edward G. Bourns, M.D., S. Thomas Carter, Jr., M.D., and John S. Madara, M.D.

May 9, 1978

Introduction of New Members . . . Welcomed John P. Kengeter, M.D., 4th District, Alexander D. Kovacs, M.D., and Myles C. Morrison, Jr., M.D., 1st District, newly elected members of the Board, and noted that Augustus L. Baker, Jr., M.D., had been elected 2nd Vice-President.

Election of Chairman of the Board . . . Re-elected James S. Todd, M.D., as Chairman of the Board of Trustees and agreed to continue meeting regularly at 10 a.m. on the third Sunday of each month, in the Executive Offices (meetings subject to cancellation when the agenda proves insufficient).

Committee on Finance and Budget . . . Reappointed Richard E. Lang, M.D., to membership on the Standing Committee on Finance and Budget for a three-year term (1978-1981).

Investigation of Pharmacies . . . Agreed, upon request from the State Board of Medical Examiners, to supply the names of physicians willing to provide prescriptions for drugs (as part of an investigatory procedure covering pharmacies suspected of violating statutes regarding the dispensing of drugs) by having the personnel of the Board so serve.

. . . Directed that the investigating agent be instructed to identify himself at the time he approaches a participating Trustee.

Annual Meeting . . . Agreed to defer the April 16th report of the Committee on Annual Meeting until the July 16 meeting of the Board of Trustees.

. . . Directed that the tentative arrangements made with the Cherry Hill Hyatt House for the 1979 Annual Meeting be finalized, and that the Committee on Annual Meeting investigate the options available for the 1980 Annual Meeting and present them at the July 16 meeting of the Board.

New Jersey Hospital Association . . .

Referred to the Executive committee the matter of replacement for Rudolph C. Gering, M.D., who resigned recently as MSNJ's liaison representative to the New Jersey Hospital Association.

Note: Subsequently Alfred A. Alessi, M.D., was appointed to serve in this capacity.

New Jersey State Medical Underwriters, Inc. . . . Approved the reappointment of James E. George, M.D., J.D., Paul J. Kreutz, M.D., John S. Madara, M.D., James S. Todd, M.D., Vincent A. Maressa, J.D., and representatives of the New Jersey Association of Osteopathic Physicians and Surgeons, Mr. Robert P. Chapman and Robert S. Mauer, D.O., to the Board of Directors of the New Jersey State Medical Underwriters, Inc.

. . . Approved retaining the accounting firm of Ernst and Ernst as accountants for the New Jersey State Medical Underwriters, Inc.

AMA Annual Meeting . . . Authorized the attendance (with expenses paid) of Louis F. Albright, M.D., Chairman of MSNJ's Ad Hoc Committee To Review the National Commission Report on the Cost of Medical Care, at the AMA's 1978 Annual Meeting in St. Louis.

Bylaws Amendment . . . Referred the following proposed amendment to the Bylaws, Chapter I—Membership, Section 2—List of Members, to the Committee on Finance and Budget for study, noting that since the proposal affects the county societies, input will be requested from county executives. (*Note:* The italicized words indicate the amendments.)

(b) Five (5) days before the first of *January* the treasurer of each component society shall forward to the Treasurer of this Society a complete list, with names and addresses, of all paid up and exempt members in good standing in this Society, at the same time remitting the assessment covering such membership.

Not later than the first day of *February* in each year, the secretary of each component society shall send to the Secretary of this Society a current list of associate, emeritus, and honorary members; members elected, deceased, and those who have resigned or moved from the county since the last report was submitted. Where members have transferred or have been received on transfer, the name of the county or state society to or from which they have transferred must be given. Not later than the first day of *March* in each year, the secretary of each component society shall send to the Secretary of this Society a complete list of the delegates and alternate

delegates to this Society, together with the names of the delegate and alternate delegate to the Nominating Committee.

Mandatory AMA Membership . . . Directed that Resolution #1—Mandatory AMA Membership (Bergen County Medical Society)—be referred to the Committee on Revision of Constitution and Bylaws:

RESOLVED, that the Medical Society of New Jersey adopt a membership policy that requires membership in the American Medical Association.

Support Concept of Hospices . . . Directed that Resolution #2—Support Concept of Hospices (Gertrude Oberlander Ash, M.D., Delegate, Essex County)—be referred to the Council on Public Relations and to the New Jersey Delegation to the AMA:

RESOLVED, that the Medical Society of New Jersey support the concept of hospices so that people who are terminally ill may die in surroundings more homelike and congenial than the usual hospital environment; and be it further

RESOLVED, that the Medical Society of New Jersey contact all media in the State to indicate that physicians consider this specialized approach to terminal care to be of great value; and be it further

RESOLVED, that a resolution of support for this concept be drafted and sent to the AMA and have the support of our New Jersey Delegation to their national House of Delegates.

Use of Amphetamines . . . Directed that a copy of Resolution #3—Use of Amphetamines (Burlington County Medical Society)—be sent to the State Board of Medical Examiners, the Attorney General, and the Deputy Attorney General:

RESOLVED, that clinical use of amphetamines and certain related sympathomimetic amines include: narcolepsy, minimal brain dysfunction, depression, seizure disorders in conjunction with other appropriate medications, hypersomnia, and that the use of amphetamines and certain related sympathomimetic amines be considered not usually an acceptable modality of treatment of obesity; and be it further

RESOLVED, that the Medical Society of New Jersey request the State Board of Medical Examiners to adopt the following procedures:

- (a) That in the future all prescribing standards be drawn up only after consultation with physicians who have working knowledge of the drugs in question;
- (b) That once adopted, the standards must be disseminated *promptly* to all practicing physicians in the State;
- (c) That the standards *never* be applied retroactively;
- (d) That physicians suspected of wrongdoing

must be evaluated by appropriate peer review committees and consultation must be obtained from these committees by concerned State agencies before a determination of guilt is made;

(e) That punishments to be meted out must be made commensurate with the severity of the violation;

(f) That in appropriate instances, rehabilitation, rather than punishment, should be the goal for which we strive; and be it further

RESOLVED, that the Medical Society of New Jersey, through its Board of Trustees, transmit the foregoing proposals to the State Board of Medical Examiners and seek the adoption of the guidelines by the State Board of Medical Examiners.

Continuing Medical Education . . . Directed that as a consequence of the action of the House of Delegates—"as of January 1, 1979, those physicians who are not in compliance with the CME requirements of the 1972 House of Delegates be dropped from the Medical Society of New Jersey"—a registered letter, return receipt requested, with a copy of the remarks of Edwin H. Albano, M.D., President of the State Board of Medical Examiners, to the House of Delegates, to the effect that the State Board of Medical Examiners is formulating a regulation whereby CME will be a mandatory prerequisite to obtaining a license to practice medicine, be sent to MSNJ members who have not met the CME requirements, and that a list of the delinquent members be sent to the corresponding county societies and to the members of the Board of Trustees of the respective counties.

. . . Directed further that the Executive Committee meet with Dr. Albano to correlate the actions proposed by the State Board of Medical Examiners with CME requirements of MSNJ.

Family Practice at the College of Medicine and Dentistry of New Jersey . . . Directed that a copy of Resolution #6—Establish Family Practice Department at the College of Medicine and Dentistry of New Jersey—New Jersey Medical School (Essex County Medical Society)—be sent to the Dean of the College of Medicine and Dentistry of New Jersey—New Jersey Medical School, and to the Academic Policy Committee of the College:

RESOLVED, that the Medical Society of New Jersey petition the Board of Trustees of the College of Medicine and Dentistry of New Jersey to establish a Department of Family Practice at the New Jersey Medical School on an equal status with other major departments in the School; and be it further

RESOLVED, that the Medical Society of New Jersey petition the New Jersey Medical School to establish a curriculum which would provide adequate teaching of medical students by family practitioners during the second, third, and fourth years of medical school.

Shared Use of the Proposed Basic Science Facility . . . Directed that a copy of Substitute Resolution #20—Shared Use of the Proposed Basic Science Facility in South Jersey by Both Allopathic and Osteopathic Students (Camden County Medical Society)—be forwarded to the Board of Trustees of the College of Medicine and Dentistry of New Jersey and to the New Jersey Association of Osteopathic Physicians and Surgeons, requesting the latter to support MSNJ's position as set forth in this resolution:

RESOLVED, that the House of Delegates insists that the use of any basic science facility in South Jersey be dedicated to the mutual use of allopathic and osteopathic programs; and be it further

RESOLVED, that the House of Delegates instruct the Board of Trustees actively to project to the State Legislators the deep concern of this House; and be it further

RESOLVED, that a copy of this Resolution be forwarded to the Board of Trustees of the College of Medicine and Dentistry of New Jersey.

Separate Facilities for Nonsmokers . . . Directed that a copy of Substitute Resolution #15—Separate Facilities for Nonsmokers (Gertrude Oberlander Ash, M.D., Delegate, Essex County)—be sent to the New Jersey State Department of Health:

RESOLVED, that the Medical Society of New Jersey petition the New Jersey Department of Health to recommend that "no smoking" signs be displayed in all public places such as banks, department stores, etc.; and be it further

RESOLVED, that the Medical Society of New Jersey work with the New Jersey Department of Health to recommend that all New Jersey eating places open to the public provide separate sections, and where feasible, separate rooms for smokers and nonsmokers.

Smoking . . . Directed that Resolution #16—Smoking (Middlesex County Medical Society)—be referred to the AMA with an appropriate accompanying letter:

RESOLVED, that the Medical Society of New Jersey applaud the efforts of the Secretary of HEW in this regard (referring to the Secretary's attack against smoking); and be it further

RESOLVED, that the Medical Society of New Jersey abhors the advertising of all

smoking products and recommends that such advertising be banned in all media; and be it further

RESOLVED, that the Medical Society of New Jersey abhors the federal subsidies to the tobacco industry and recommends that the subsidies be halted and this money be used for an appropriate time to develop alternate farm crops; and be it further

RESOLVED, that the AMA use all appropriate measures to accomplish these purposes.

Professional Liability Insurance Coverage . . . Directed that Resolution #4—Professional Liability Insurance Coverage (Hudson County Medical Society)—be referred to the Committee on Medical Defense and Insurance and to MSNJ's liaison representative to the New Jersey Hospital Association:

RESOLVED, that the Medical Society of New Jersey involve itself in the problem caused by inadequate insurance coverage for physicians who are acting in an administrative capacity in their hospitals, and resolve the inequity with the involved hospital insurance companies and medical liability carriers.

Physician and Administrative Non-Medical Immunity . . . Directed that Resolution #7—Physician and Administrative Non-Medical Immunity (Bergen County Medical Society)—be referred to the Council on Legislation:

RESOLVED, that the Medical Society of New Jersey support, develop, or cause to be introduced legislation granting civil immunity to administrative non-medical personnel of the medical societies acting for the public good and involved in peer review and other administrative activities; and be it further

RESOLVED, that the Medical Society of New Jersey support, develop, or cause to be introduced legislation granting civil immunity to those physicians involved in peer review and administrative activities.

Inform Public of Harmful Effects of Marijuana . . . Directed that Resolution #8—Inform Public of Harmful Effects of Marijuana (Essex County Medical Society)—be referred to the Council on Public Relations:

RESOLVED, that the Medical Society of New Jersey utilize all available media to inform the public that marijuana is not a harmless nor innocuous drug; and be it further

RESOLVED, that the Medical Society of New Jersey advise the public that decriminalization is not legalization nor medical approval for its use as a drug.

Oppose Physicians' Assistant Licensure . . . Directed that a copy of Resolution #9—Oppose Physicians' Assistant Li-

censure (Essex County Medical Society)—be sent to the State Board of Medical Examiners, and as informational, to the Council on Legislation:

RESOLVED, that the Medical Society of New Jersey continue to oppose the licensure and/or registration of physicians' assistants, because no definite need has been established.

Opposition to National Health Insurance . . . Agreed to place Resolution #10—Opposition to National Health Insurance (Frank J. Primich, M.D., Delegate, Hudson County)—on the agenda for the July 16 meeting, and directed that a copy of H.R. 1818, as presently written, as well as a statement of MSNJ's former position on the same bill, be sent to the Board for review:

RESOLVED, that the Medical Society of New Jersey go on record as being opposed to any form of National Health Insurance; and be it further

RESOLVED, that the Medical Society of New Jersey withdraw its support of H.R. 1818, the American Medical Association sponsored version of National Health Insurance.

Committee on Impaired Physicians . . . Directed that Resolution #12—Committee on Impaired Physicians (Committee on Impaired Physicians and Board of Trustees)—be referred to the state and county women's auxiliaries, the county medical societies (for publication in their respective newsletters), the New Jersey Hospital Association (for distribution to hospital and nursing home administrators), and the New Jersey Association of Osteopathic Physicians and Surgeons as well as to the State Board of Medical Examiners and the State Department of Health:

RESOLVED, that the House of Delegates take steps to disseminate information regarding the existence of the Committee and its non-punitive, therapeutic, and advocacy approach to the impaired physician. These steps shall include special communications to each County Medical Society, the State and County Osteopathic organizations, the State and County Medical Society Women's Auxiliaries, the New Jersey Hospital Association and each hospital administrator in the State, every licensed M.D. and D.O. in New Jersey, the appropriate State and County Nursing and Pharmacy organizations, and all other pertinent organizations and individuals.

Medicaid Funding and Provider Reimbursement . . . Directed that Substitute Resolution #22—Medicaid Funding and Provider Reimbursement (John Winslow, M.D., Delegate, Essex County)—be referred to the Executive Committee and Legal Counsel for de-

termination of anti-trust implications, for review of the Medicaid Law to determine if the resolution can be operative, and for factual evaluation:

RESOLVED, that the Medical Society of New Jersey call to the attention of the Secretary of Health, Education, and Welfare, the Governor, the Legislators, the Commissioner of Human Resources, and the public through the news media, the resulting discrimination against minority patients and physicians and the inequity of the payments for the medical services of the Medicaid patients to their own family doctor vs. the payments to the hospital out-patient services for this care, which are at least 500 percent greater than the payment for the same services in a doctor's office; and be it further

RESOLVED, that the Medical Society of New Jersey urge all its member physicians who have only a small percentage of Medicaid patients in their practice no longer to bill Medicaid for services to these patients, although they should continue to provide care to them in the highest traditions of medical practice; and be it further

RESOLVED, that as a mechanism to accomplish this in a satisfactory and documented fashion, the Medical Society of New Jersey directly should solicit its membership, through first-class mail and pledge cards, to agree to see their Medicaid patients without billing Medicaid for their services, thus putting Medicaid of New Jersey in noncompliance with federal regulations. This procedure of seeing patients but not billing for them would continue until the New Jersey Legislature provides sufficient funds so that Medicaid can reimburse physician providers on a parity with Medicare rates; and be it further

RESOLVED, that as soon as a sufficient number of pledge cards are received, the Board of Trustees of the Medical Society of New Jersey inform the Secretary of the Department of Health, Education, and Welfare, that the State of New Jersey is not in compliance with Medicaid regulations.

Government Regulation—Health Care Cost Escalation . . . Directed that Resolution #13—Government Regulation—Health Care Cost Escalation (Hudson County Medical Society)—be referred to the Council on Public Relations:

RESOLVED, that the Medical Society of New Jersey be the first state medical society to have the courage to lay the blame where it belongs, on government intrusion; and be it further

RESOLVED, that our public relations efforts be directed toward informing the public, our patients, of the visible and hidden costs of current and proposed governmental actions.

Group Health Services, Inc. . . . Directed that Resolution #14—Group Health Services, Inc. (Mercer County Medical Society)—be referred to the AMA delegation:

RESOLVED, that the AMA oppose third party differential between services covered by participating and nonparticipating physicians as discriminatory and against a physician who does not have a separate contractual relationship with the carrier and inhibiting the patient's free choice of physician; and be it further

RESOLVED, that this position be communicated to all health insurance carriers.

Reimbursement of President and Chairman of the Board . . . referred Resolution #23—Reimbursement of President and Chairman of the Board (Barbara A. Mazzella, M.D., Delegate, Bergen County)—to the Committee on Finance and Budget:

RESOLVED, that the President of the Medical Society of New Jersey's stipend be in-

creased to \$75,000 a year for the year he or she is in office and \$25,000 for the first year out of office; and be it further

RESOLVED, that the Chairman of the Board of Trustees of the Medical Society of New Jersey be given an annual stipend of \$25,000; and be it further

RESOLVED, that these stipends are to help defray the physicians' loss of income during his or her tenure.

The Health Systems Agency (HSA): A Primer

In 1974, Congress passed Public Law 93-641, the National Health Planning and Resources Development Act, which was a consolidation of and replacement for the antecedent Hill-Burton program (funds for hospital construction), Regional Medical Programs (RMP), and Comprehensive Health Planning Act (CHP).

PRIORITIES

The ten national health priorities stated by the Congress in the act are:

1. The provision of primary care services for medically underserved populations, especially those which are located in rural and/or economically depressed areas.
2. The development of multi-institutional systems for coordination or consolidation of institutional health services (including obstetric, pediatric, emergency medical, intensive and coronary care, and radiation therapy services).
3. The development of medical group practices (especially those whose services are appropriately coordinated or integrated with institutional health services), health maintenance organizations (HMOs), and other organized systems for the provision of health care.
4. The training and increased utilization of physician assistants, especially nurse clinicians.
5. The development of multi-institutional arrangements for the sharing of support services necessary to all health services institutions.
6. The promotion of activities to achieve needed improvements in the quality of health services, including needs identified by the review activities of Professional Standards Review Organizations (PSRO), under Part B of Title XI of the Social Security Act.
7. The development by health service institutions of the capacity to provide

various levels of care (including intensive care, acute general care, and extended care) on a geographically integrated basis.

8. The promotion of activities for the prevention of disease, including studies of nutritional and environmental factors affecting health and the provision of preventive health care services.

9. The adoption of uniform cost accounting, simplified reimbursement and utilization reporting systems and improved management procedures for health service institutions.

10. The development of effective methods of educating the general public concerning proper personal (including preventive) health care and methods for effective use of available health services.

HEALTH SERVICE AREAS

The legislation mandated the division of the nation into 204 health service areas according to the following criteria:

- Area shall be a geographic region appropriate for effective planning and development of health services, determined on the basis of factors including population and availability of resources
- The population should be between 500,000 and 3,000,000
- Each area should contain all health resources including, if practical, one center providing highly specialized health services
- The boundaries of the area shall be appropriately coordinated, to the extent practicable with the boundaries of Professional Service Review Organizations (PSROs), existing regional planning areas and State planning and administrative areas. Standard Metropolitan Statistical Areas (SMSAs) were not to be split, unless governors agreed in cases where these crossed state lines

There are five HSAs in New Jersey: Bergen-Passaic Health Service Agency, Health Service Area I; Bergen and Passaic Counties. Regional Health Planning Council,

Health Service Area II; Essex, Sussex, Morris, Union and Warren Counties.

Hudson Health Services Agency, Health Service Area III; Hudson County.

Central Jersey Health Planning Council, Health Service Area IV; Hunterdon, Mercer, Middlesex, Monmouth, Ocean and Somerset Counties.

Southern New Jersey Health Systems Agency, Health Service Area V; Atlantic, Burlington, Camden, Cape May, Cumberland, Gloucester, and Salem.

ORGANIZATION

The national health planning functions are directed by the Secretary of the Department of Health, Education, and Welfare (DHEW) with the advice of a National Council on Health Policy and Development. The latter is composed of 15 members, including the chief medical director of the Veterans' Administration, Assistant Secretary for Health and Environment (Department of Defense), Assistant Secretary of Health (DHEW), and 12 members appointed by the Secretary.

In New Jersey there are two master agencies:

1. *Statewide Health Coordinating Council (SHCC)*, whose functions are:

- Annually review and coordinate Health Systems Plans (HSPs) and Annual Implementation Plans (AIPs) of the HSAs
- Approve State Health Plan based on health service plans of the HSAs
- Review HSA budgets
- Approve state plan and application by state for allotments to the states made under Public Health Service (PHS), Community Mental Health Centers (CMHC), and Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation (CAAPTR)

The SHCC is composed of 16 to 40 persons appointed by the Governor. Sixty percent of them must be selected from HSA nominees and the majority of appointees must be consumers.

2. State Planning and Developmental

Agency, whose functions are:

- Prepare State Health Plan based upon health service plans of the HSAs
- Assist SHCC in reviewing state medical facilities plans
- Administer Certificate of Need and review Section 1122 of the Social Security Act
- Review every five years all institution services as to appropriateness

This is an agency of the state selected by the Governor and approved by the Secretary, DHEW.

WHAT IS THE HSA?

The HSA is a public or private non-profit corporation or public regional planning body. The composition of its board of directors must include at least 51 percent (but not more than 60 percent) consumers, while the remainder are providers. Elected officials can qualify in either category, but may not assume more than one-third of the seats on the Board. The providers include health care professionals (physicians, nurses, dentists), health care institution administrators, health care insurers, representatives from health professional schools and from allied health professions. At least one-third of the providers must be involved in direct diagnosis and treatment.

What Does HSA Do?

- Collect and analyze data
- Establish, implement, and annually update Health Systems Plan (HSP)
- Establish, implement, and annually update Annual Implementation Plan (AIP)
- Coordinate activities with PSROs
- Review funds for NIH grants, nursing training, health professional manpower, if the funds are designated for the development of resources to be used in the health service area
- Make recommendations to the State Health Planning and Development Agency concerning facility certification, Section 1122 review
- Make recommendations to the State Agency at least every five years concerning the appropriateness of existing services and facilities
- Recommend priorities for modernization, construction, and conversion of health facilities

HOW IS HSA FUNDED?

The HSA is funded by a grant from DHEW based on a rate of fifty cents per capita within the geographic service area. Additional matching federal dollars may be available where funds are obtained from other sources. When the HSA Health Systems Plan (HSP) and Annual Implementation Plan (AIP) have been approved by DHEW, the HSA will be awarded "full designation." This then makes the HSA eligible to apply for, receive, and allocate funds in the form of grants, low-interest loans, and in other forms to achieve the goals of the HSP.

THE HEALTH SYSTEMS PLAN (HSP)

Each of the five New Jersey HSAs is required to develop an HSP for the region it covers. The Plan is based on a broad overview of the existing health system and must include those explicit details which are set forth in PL93-641. To accomplish this the HSA must collect and analyze data from its region regarding:

- a. the status (and its determinants) of the health of the population;
- b. the status and use of the health care delivery system;
- c. the effect the health care delivery system has on the population;
- d. documentation of the health care resources including services;
- e. patterns of utilization of the health resources;
- f. environmental and occupational exposure factors affecting immediate and long-term health conditions.

In the development of the Plan, all of these factors must be considered in the light of national priorities. The HSP contains goals which deal with particular health issues (e.g., infant mortality rate, the incidence of drug and alcohol-related health problems, and so on) but are not constrained by time (unlike the AIP). The general goals of the HSP are:

- a. To improve the health of the residents of the region;
- b. To improve health services including availability, accessibility, acceptability, continuity, and quality;
- c. To restrain increases in the cost of health care;
- d. To consider feasibility of imple-

mentation (of specific goals).

Overall health status goals include items such as the reduction of infant mortality rates, the reduction of morbidity from specific disorders, reduction in crude death rates, reduction in the incidence of such problems as drug and alcohol abuse, and so on. Health *systems* goals relate to quality, accessibility, and acceptability of health services, availability of primary care sources, acute inpatient services, renal dialysis stations, CT scanner units, mental health services, home health services, and so on.

Thus, the HSP takes a broad overview of the existing health status and system and proposes a program for expanding, contracting, or modifying the services, which comprise the system in order to approach and, where possible, to meet the needs of the citizens. The HSP is used as the basis for conducting Certificate of Need reviews.

The HSP must be approved by the Statewide Health Coordinating Council (SHCC); it is reviewed annually.

ANNUAL IMPLEMENTATION PLAN (AIP)

The AIP consists of those portions of the HSP which the constraints of funds and time suggest are feasible and which are given the highest priority for the year. The AIP must be reviewed by SHCC.

STATE HEALTH PLAN

The State Planning and Development Agency prepares a State Health Plan based upon the health systems plans (HSPs) of each of the five HSAs. The Agency also develops a State Medical Facilities Plan which likewise is a composite of the appropriate portions of the five HSPs. The latter includes:

1. The number, type, and distribution of medical facility beds and medical facilities needed to provide adequate inpatient care throughout New Jersey.
2. The number, type, and distribution of outpatient and other medical facilities needed to provide adequate public health services and out-patient care.
3. The extent to which existing New Jersey medical facilities need modernization or conversion to new uses.

The State Health Plan and the State Medical Facilities Plan must be approved by SHCC and DHEW.

A. Krosnick, M.D.

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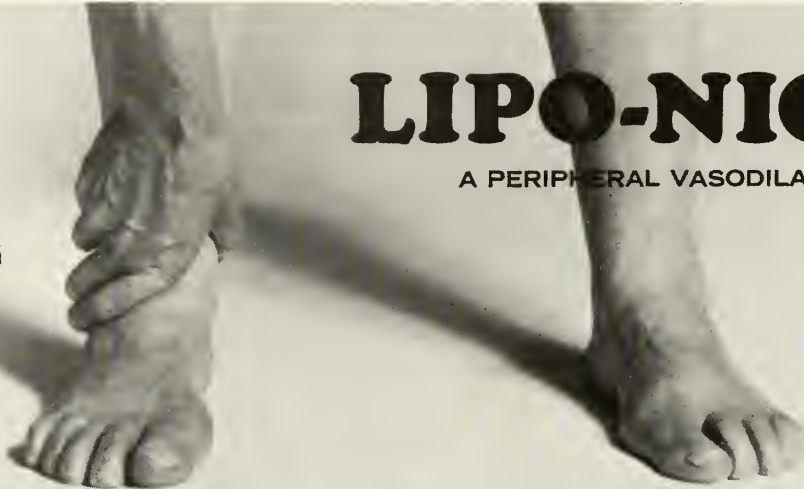
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- (a) "Licensee" for the purpose of this regulation means a person possessing a plenary license to practice medicine and surgery, a podiatrist, a chiropractor, a physical therapist or a director of a bioanalytical laboratory.
- (b) A licensee in the State of New Jersey may provide information to the public, by publication in a dignified manner in newspapers or comparable written publications concerning: education, certification or appointment, location and availability of services, fees for routine professional services and other pertinent information about the licensee's practice. On any such publication, license degree must be designated. To the extent that information provided to the public by the licensee may be misleading, the licensee shall provide clarification, such as, but not limited to, whether additional charges may be incurred for related services when fees are stated.
- (c) Information provided to the public in accordance with section (b) shall not by form, manner or content be such as to solicit patients. Solicitation is prohibited. Solicitation shall include, but is not limited to, public information which may be found by the New Jersey State Board of Medical Examiners as:
1. False, fraudulent, deceptive, misleading, or flamboyant;
 2. Representing intimidation or undue pressure;
 3. Using testimonials;
 4. Guaranteeing any service or guaranteeing that satisfaction or cure will result from the professional services offered;
 5. Offering gratuitous services or discounts in connection with published services, but this clause shall not be construed to relate to the negotiation of fees between licensees and patients or clients, or to prohibit the rendering of professional services for which no fee is charged;
 6. Making claims of professional superiority;
 7. Stating or including prices for professional services which are false, deceptive or misleading.
- (d) The information which may be provided to the public is limited to the printed media and any such information provided by a licensee in any other form is expressly prohibited.
- (e) Any violation of the foregoing rule

- may be considered as the basis for suspension or revocation proceedings being instituted against the licensee.
- (f) This rule supersedes any prior rule to the extent inconsistent therewith.
- Physicians Seeking Location in New Jersey**
- The following physicians have written to the Executive Office of MSNJ seeking information on possible opportunities for practice in New Jersey. The information listed below has been supplied by the physician. If you are interested in any further information concerning these physicians, we suggest you make inquiries directly to them.*
- AEROSPACE MEDICINE**—Laurence H. Blackburn, Jr., M.D., 56 Woodcrest Lane, Doylestown, Pennsylvania 18901. Johns Hopkins University 1955. Board certified. Industrial, group, or administrative. Available August 1978.
- ANESTHESIOLOGY**—Jitendra G. Patel, M.D., 133-52 Avery Avenue, Flushing, New York 11355. M. P. Shah Medical College (India) 1972. Board eligible. Group, partnership, solo. Available July 1978.
- Arundev Dahyabhai Desai, M.D., 7-29 Hugman Ave., Apt. 17-C, Brooklyn, NY 11212. B.J. Medical College (India). Board eligible. Group, partnership, solo, salaried. Available.
- Mahendra N. Sampat, M.D., Nassau County Medical Center, 2201 Hempstead Turnpike, East Meadow, New York 11554. Calcutta (India) 1969. Board eligible. Group, partnership, institution. Available.
- Yi Shien Lin, M.D., 636 Brooklyn Avenue, Apt. 14-C, Brooklyn, New York 11203. Koahsiung (Taiwan) 1968. Board eligible. Group or partnership. Available.
- Cesar A. Souza, M.D., 331 Theatre Drive, 1C14, Johnstown, PA 15904. Montevideo (South America) 1967. Board eligible. Group or solo. Available.
- Alan D. Weinstock, M.D., 320 Ocean Parkway, Brooklyn, New York 11218. Albert Einstein 1974. Board eligible. Group, partnership, or institution. Available.
- CARDIOVASCULAR DISEASES**—Sae Kirl Kim, M.D., 8-C Borden Apartments, Third Avenue, Long Branch 07740. Chonnam University (Korea) 1967. Subspecialty, internal medicine. Board eligible (IM). Group, partnership. Available.
- W. Bruce Fye, M.D., 307 Overbrook Road, Baltimore, Maryland 21212. Johns Hopkins 1972. Subspecialty, internal medicine. Board certified (IM). Group or institution. Available.
- Anil G. Kothari, M.D., 9500 Euclid Avenue, Cleveland, Ohio 44106. Topiwala Medical School (India) 1972. Subspecialty, internal medicine. Board certified (IM). Group, partnership, institution. Available.
- DERMATOLOGY**—Robert W. Gurney, M.D., 333 East Ontario Street, #4309, Chi-

- cago, Illinois 60611. Georgetown 1974. Board eligible. Group or partnership. Available.
- EMERGENCY MEDICINE**—Raymond P. Limansky, M.D., 950 49th Street, Apt. 4-F, Brooklyn, New York 11219. University of Barcelona 1974. Subspecialty, general practice. Solo or emergency room. Available.
- Karshandas N. Kacha, M.D., 61 Bross Place, Apt. 15-A, Irvington 07111. B.J. Medical College (India) 1969. Subspecialty, family practice. Group, emergency room. Available.
- ENDOCRINOLOGY**—Jamshid Alizadeh, M.D., 1427 East Willow Lake Drive, NE, Atlanta, Georgia 30329. Tehran Medical School (Iran) 1968. Subspecialty, internal medicine. Board certified (IM). Group, public or school health, institution. Available September 1978.
- Frederick E. Lewis, M.D., 445 East 68th Street, Apt. 4-B, New York, New York 10021. Albany Medical College 1971. Subspecialty, internal medicine. Board certified (IM). Group, partnership, or solo. Available.
- FAMILY PRACTICE**—Gwendolyn D. Williams, M.D., 557 W. 141st Street, New York, New York 10031. University of Zurich 1963. Subspecialty, pathology. Board eligible (path.). Group or public health. Available.
- Lawrence I. Weissman, M.D., 10 Salem Park, Elizabeth, New Jersey 07208. New York Medical College 1975. Board eligible. Group or partnership. Available.
- Thomas P. Harakal, M.D., 202 Laura Drive, Danville, Pennsylvania 17821. Temple 1975. Board eligible. Group, partnership, research. Available.
- Julio E. Pardave, M.D., 2650 Selwyn Avenue, Apt. 20-D, Bronx, New York 10457. San Marcos (Peru) 1973. Subspecialty, pediatrics. Board eligible, pediatrics. Group, partnership, public health. Available.
- Janet Crane Vassar M.D., 2029 Nuuanu Avenue, Honolulu, Hawaii 96817. Medical College of Pennsylvania 1977. Partnership, school health, solo. Available.
- GASTROENTEROLOGY**—Robert A. Sable, M.D., 2500 F Johnson Avenue, Apt. 15-A, Bronx, New York 10463. Einstein College of Medicine 1973. Subspecialty, internal medicine. Board certified (IM). Group, partnership. Available.
- Philip J. Di Giacomo, Jr., M.D., 2108 B Crosby Street, Philadelphia, Pennsylvania 19112. Jefferson 1972. Subspecialty, internal medicine. Board certified (IM). Group, partnership. Available July 1979.
- GYNECOLOGY**—S. Stanley Barr, M.D., 255 South 17th Street, Philadelphia, Pennsylvania 19103. Hahnemann 1933. Board certified (obstetrics & gynecology). Group or partnership. Available.
- HEMATOLOGY**—Jean Bello Belasco, M.D., 34 Fidelity Courts, Carrboro, North Carolina 27510. Temple University 1973. Subspecialty, pediatrics. Board eligible (pediatrics). Institution, group, or research. Available.

INTERNAL MEDICINE—John R. Keiper, M.D., 3900 Park Avenue, Apt. 1-B, Bridgeport, Connecticut 06604. University of Texas 1976. Board certified. Group, partnership. Available July 1979.

Y. E. Szoke, M.D., 800 Forest Avenue, Apt. 15-E, Westfield 07090. Board eligible. Family practice setting, group, partnership, solo, associate. Available July 1978.

Stephen Winograd, M.D., 208 Walnut Street, Montclair 07042. NYU 1972. Subspecialty, gastroenterology. Board certified. Group, partnership, solo. Available.

Martin R. Mersky, M.D., 1722B Ferndale Avenue, Abington, Pennsylvania 19001. Jefferson 1975. Board eligible. Group, partnership, solo, institution, industrial, academic, or public health. Available August 1978.

Sang Hee Park, M.D., 102 Livermore Street, Boston, Massachusetts 02126. Catholic Medical College (Korea). Subspecialty, nephrology. Board certified (IM). Group or partnership. Available.

Barry J. Buls, M.D., 710 East Seventh Street, Brooklyn, New York 11218. New York Medical College 1975. Board eligible. Group, partnership, solo. Available.

Jameel Katmeh, M.D., Deborah Heart and Lung Center, Browns Mills 08015. Damascus (Syria) 1972. Subspecialty, cardiovascular diseases. Board eligible (cardiovascular diseases). Group or partnership. Available.

Dunthur M. Puttaswamy, M.D., 10A Southgate Apts., 272 Ward Avenue, Bordentown 08505. University Medical College, Mysore (India) 1954. Board eligible. Group, solo, or institution. Available.

Alexander D. Shimanovsky, M.D., 221 Morris Avenue, Summit 07901. Ist Medical Institute (Russia) 1971. Board eligible. Group or partnership. Available.

Drew Paul Ronnermann, M.D., 275 Bryn Mawr Avenue, Apt. K-43, Bryn Mawr, Pennsylvania 19010. New York Medical College 1974. Subspecialty, gastroenterology. Board certified. Group or partnership. Available July 1979.

NEPHROLOGY—Prakash Ananthanarayan, M.D., 1590 Anderson Avenue, Apt. 16-D, Fort Lee 07024. Calicut (India) 1970. Subspecialty, internal medicine. Board certified (IM). Group, partnership, solo. Available.

Joseph Jyh Chung Lee, M.D., 5131 Wissoming Road, Washington, DC 20016. National Taiwan University 1971. Subspecialty, internal medicine. Board certified (IM). Group, partnership, institution. Available.

Allan A. Shook, M.D., 32 East Gravers Lane, Philadelphia, Pennsylvania 19118. NYU, Syracuse 1973. Board eligible. Group or partnership. Available.

NEUROLOGY—Riaz A. Janjua, M.D., 153 West 11th Street, New York, NY 10011. King Edward, Lahore (Pakistan) 1972. Board eligible. Group, partnership, solo, research, public health, school health. Available.

Alan J. Tuchman, M.D., 828 Talbott Road, Wright-Patterson AFB, Ohio 45433.

University of Cincinnati 1972. Board eligible. Group, institution, partnership, industrial, public health, administrative. Available.

Jan J. Golnick, M.D., 4 Park Avenue, Apt. 8E, New York, NY 10016. Silesian School of Medicine (Poland) 1967. Board eligible. Group, partnership, institution. Available.

OBSTETRICS/GYNECOLOGY—Dong Wook Shin, M.D., 850 Station Avenue, Cornwells Heights, Pennsylvania 19020. Korea University. Board eligible. Solo or partnership. Available July 1978.

William L. Schneiderman, M.D., 71 Woodside Circle, Lakeridge, Torrington, CT 06790. NYU 1974. Board eligible. Group or partnership. Available.

Iraj Nakhjavan, M.D., 122-1/2 Center Street, Ridgway, PA 15853. Tehran (Iran) 1961. Subspecialty, family practice. Solo, partnership, group. Available.

Kamrul Hasan, M.D., 18220 Lorain Avenue, Apt. 66, Cleveland, OH 44111. Dow Medical College (Pakistan) 1972. Board eligible. Group, research, partnership. Available.

Saud A. Tarawneh, M.D., 2212 Foxbourne Road, Toledo, OH 43614. Damascus (Syria) 1967. Board eligible. Solo, partnership, group. Available.

Susane L. Friedlander, M.D., 305 East 24th Street, Apt. 10-C, New York, NY 10010. NYU 1974. Board eligible. Group, partnership. Available September 1978.

OCCUPATIONAL MEDICINE—Lawrence Z. Shultzaberger, M.D., 10 Pinecrest Drive, Cortland, NY 13045. Hahnemann 1951. Industrial, school health, administrative. Available.

OPHTHALMOLOGY—Edward Y. Shen, M.D., 636 Brooklyn Avenue, Brooklyn, NY 11203. Kaohsiung (Taiwan) 1966. Board eligible. Any type practice. Available.

Michael J. Newton, M.D., 1370 Veteran Avenue, Apt. 119, Los Angeles CA 90024. Tufts 1971. Board eligible. Partnership, group, solo, research. Available.

Javad N. Sani, M.D., 2301 6th Street, South, Apt. 3, Arlington, VA 22204. Tehran (Iran) 1972. Board eligible. Research, group, partnership. Available.

Nissim Joseph, M.D., 110 Babcock St., Apt. 41, Brookline, MA 02146. Tel-Aviv University (Israel) 1968. Board eligible. Group, research, partnership, solo. Available.

PATHOLOGY—Raja Ranasinghe, M.D., 124 Lake Street, Englewood 07631. University of Ceylon (Sri Lanka) 1969. Board certified in anatomic and clinical pathology. Group, solo, industrial, or hospital. Available.

Vidya Deshpande, M.D., 11433 Maridosa Trail, Apt. B, Florissant, Missouri 63033. B.J. Medical College (India) 1970. Board certified. Special interest, anatomic and clinical pathology. Group. Available July 1978.

Solomon Rendler, M.D., 1482 E. 8th Street, Brooklyn, NY 11230. Wisconsin 1974. Special interest, clinical pathology. Board certified. Institution, academic,

group. Available.

Balshik Min, M.D., 141 Old Short Hills Road, Apt. 11, West Orange 07052. Seoul University (Korea) 1966. Board eligible. Institution, group, partnership. Available.

Sangeeta A. Shah, M.D., 129 Brook Haven, Deridder, LA 70634. Grant Medical School (India) 1970. Board certified. Subspecialty, clinical pathology. Partnership, solo, group, institution, industrial. Available.

PEDIATRICS—P. N. Varma, M.D., 506 6th Street, Brooklyn, New York 11215. Rangaraya Medical College (India) 1969. Board eligible. Group or partnership. Available July 1978.

Sharda J. Doshi, M.D., 89-06 135th Street, Apt. 5-J, Jamaica, New York 11418. B. J. Medical College (India). Board eligible. Group, partnership. Available July 1978.

Kyung-Ro Kwak, M.D., 1440 Freeport Loop, Apt. 2-A, Brooklyn, New York 11239. Pusan (Korea) 1963. Board eligible. Any type practice. Available July 1978.

C. B. Rao, M.D., 1825 Parkside Drive, Apt. 1-2, Parkridge, Illinois 60068. Guftur Medical College (India) 1966. Board eligible. Partnership, group, solo. Available July 1978.

Andrew Stachewitsch, M.D., 96 Easton Avenue, Montreal West H4X 1L2, Quebec, Canada. Freiburg (Germany) 1955. Subspecialty, hematology. Board eligible (both). Solo, group, institution. Available.

Eric J. Flug, M.D., 813 Westwood Drive, Clayton, MO 63105. St. Louis University 1975. Board eligible. Partnership, group, institution, emergency room. Available.

Natalio Schwartz, M.D., 7660 SW 82nd Street, Apt. H-110, Miami, FL 33143. University of Chile 1972. Board certified. Institution, group, partnership. Available August 1978.

Mahrugh D. Bamji, M.D., 3091 Edwin Avenue, Apt. 4A, Fort Lee 07024. Grant Medical College (India) 1970. Board eligible. Institution, group. Available.

Shahina Qureshi, M.D., 200 Carman Avenue, Apt. 4-J, East Meadow, NY 11554. Dow (Pakistan) 1972. Subspecialty, hematology/oncology. Group, partnership. Available.

Anita C. Dy, M.D., 1947 85th Street, Brooklyn, NY 11214. University of the East (Philippines) 1967. Board certified. Solo, partnership, group. Available.

Burton Banner, M.D., 525 Ocean Parkway, Apt. 2A, Brooklyn, NY 11218. Downstate Medical Center 1974. Board eligible. Partnership, group. Available.

Paul S. Spivack, M.D., 7095 Santa Paula Circle, Buena Park, CA 90620. SUNY, Downstate 1975. Board eligible. Group, institution, partnership. Available.

Irving Zultan, M.D., 1935-3C Eastchester Road, Bronx, NY 10461. Albert Einstein 1974. Board eligible. Partnership, group, research. Available.

PHYSICAL MEDICINE/ REHABILITATION—Vidya J. Rao, M.D., 100 Livingston Avenue, Edison 08817. Sarojini-Naidu Medical College (India) 1971. Board eligible. Full-time job in hospital as physiatrist. Available.

Kyung Dok Yoon, M.D., 80-15 41st Avenue, Apt. 342, Elmhurst, NY 11373. Yonsei (Korea) 1971. Board eligible. Institution, group, partnership. Available.

William Green, M.D., 1935-6C Eastchester Road, Bronx, NY 10461. Guadalajara 1972. Board eligible. Group, solo. Available.

PSYCHIATRY—Kyung-Seok Han, M.D., 200 Carman Avenue, Apt. 9-G, East Meadow, New York 11554. Seoul (Korea) 1970. Board eligible. Mental health clinic or inpatient unit. Available July 1978.

PULMONARY DISEASES—Kyung Ook Yoon, M.D., 80-15 41st Avenue, Apt. 342, Elmhurst, New York 11373. Yonsei Medical School (Korea) 1971. Board eligible. Institution or partnership. Available July 1978.

RADIOLOGY—Sudarshan K. Singla, M.D., 175 Ardsley Loop, Apt. 18H, Brooklyn, NY 11239. Amritsar (India) 1969. Special interest, diagnostic radiology. Board eligible, diagnostic radiology. Partnership, group. Available.

Kundan L. Gupta, M.D., 24474 Haskell, Apt. 94, Taylor, MI 48180. Amritsar (India) 1969. Board eligible. Special interest, diagnostic radiology. Solo, group. Available.

SURGERY, CARDIOVASCULAR—Samuel C. Balderman, M.D., 5623 N. Bernard, Chicago, IL 60645. University of Illinois 1972. Subspecialty, thoracic surgery. Board certified (general surgery). Research, institution, group. Available.

SURGERY, GENERAL—Shahid H. Hashmi, M.D., 5214 Lancelot Lane, N.W., Roanoke, Virginia 24019. King Edward (Pakistan). Board eligible. Solo, partnership. Available.

B. M. Shivashankar, M.D., 32 Deanna Drive, Apt. 77, South Somerville 08876. Mysore (India) 1969. Special interest in colon and rectal surgery. Board eligible. Group, partnership, solo. Available May 1978.

Ramesh P. Shah, M.D., 3305 Broeck Pointe Court, Louisville, Kentucky 40222. Seth G.S. (India). Board eligible. Any type practice. Available.

Francis P. Badamo, M.D. 1585 Beech Street, Wantagh, New York 11793. University of Pennsylvania 1970. Board certified. Group, partnership, multi-specialty clinic. Available July 1978.

Sid Anur, M.D., 1500 East 10th Street, Winfield, Kansas 67156. Karantak (India) 1965. Subspecialty, endoscopy. Board eligible. Group, partnership, solo, or institutional. Available.

Peter R. Douglas, M.D., Two Rosewood Lane, Essex Junction, Vermont 05452. SUNY (Downstate) 1971. Board eligible. Any type practice. Available July 1978.

Alessandro Ferrero, M.D., 1915 Laird Drive, Salt Lake City, Utah 84108. Università di Torino (Italy) 1967. Special interest in thoracic and cardiovascular surgery. Board certified. Group or partnership. Available July 1978.

Shshilkumar R. Samant, M.D., Texas Heart Institute, P.O. Box 20269, Houston, TX 77025. Seth G. S. Medical College (India) 1970. Special interest, thoracic surgery. Board eligible. Any type practice. Available.

Simon B. Santos, M.D., 8720 Chestnut Circle, Apt. 4, Kansas City, MO 64131. Santo Domingo (Dominican Republic) 1972. Board eligible. Partnership, group. Available.

Rao V. Daluvoy, M.D., 950 49th Street, Apt. 9A, Brooklyn, NY 11219. Guntur (India) 1965. Board eligible. Group, partnership, solo. Available.

Anthony R. Bescher, 51 Parkview Court, Lancaster, NY 14086. Jefferson 1971. Board eligible. Group, partnership. Available.

Fitzclarence Griffith, M.D., 17310 Whitcomb, Detroit MI 48235. Univ. of West Indies (Jamaica) 1971. Subspecialty, general practice. Board eligible. Partnership, group, public health. Available.

Frank P. Gudicello, M.D., 331B Third Avenue, Long Branch 07740. University of Bologna (Italy) 1974. Board eligible. Solo, partnership, group. Available.

Carlos A. Medina, M.D., 787 Chambord Circle, Marion, OH 43302. National University (Bogota) 1971. Board eligible. Subspecialty, emergency medicine. Group, emergency room. Available.

Kyum Tak Kim, M.D., 501 Sixth Street, Apt. 10C, Brooklyn, NY 11215. Seoul (Korea) 1968. Board eligible. Partnership, solo, group. Available.

SURGERY, ORTHOPEDIC—DeWitt C. Brown, III, M.D., 1344 Fairacres Road, Rydal, Pennsylvania 19046. George Washington University 1968. Board certified. Solo, partnership. Available.

Michael G. Dolin, M.D., 100 Avenue P, Brooklyn, NY 11204. New York Medical College 1970. Board eligible. Group, partnership. Available September 1978.

Mohamed Khalafalla Nour, M.D., 237 Fairhaven Boulevard, Woodbury, NY 11797. Cairo (Egypt) 1959. Board eligible. Solo. Available.

Robert B. West, M.D., 8 Louise Lane, Tenafly 07670. Columbia 1973. Board eligible. Group, partnership. Available.

SURGERY, THORACIC—Imad F. Tabry, M.D., 1200 4th Street, NW, Rochester, MN 55901. French School of Medicine (Lebanon) 1970. Board eligible. Board certified (general surgery). Research, partnership, group. Available.

SURGERY, UROLOGICAL—Jorge A. Saborio, M.D., 30-43 69th Street, Woodside, NY 11377. National, Leon (Nicaragua) 1970. Board eligible. Group, partnership, solo. Available.

Marvin L. Stein, M.D., 3801 Hudson Manor Terrace, Apt. 5L, Riverdale, NY 10463. Board eligible. Group, partnership, solo. Available.

Paul F. Low, M.D., 128-4 Kirkbride Road, Voorhees 08043. CMDNJ 1973. Board eligible. Partnership, group, solo. Available.

Larry E. Goldstein, M.D., 552 Rossmore Road, Richmond, VA 23225. Jefferson 1973. Board eligible. Partnership, solo, group. Available.

Joel S. Cohen, M.D., 3880 La Jolla Village Drive, La Jolla, CA 92037. Guadalajara 1972. Board eligible. Partnership, group, solo. Available.

Satish A. Dhagat, M.D., 1 Liberty Street, Apt. C-12, Little Ferry 07643. B.J. Medical College (India) 1966. Board eligible. Group, partnership. Available.

UROLOGY—Bhuta Dharampal, M.D., 1935 Eastchester Road, Apt. 3-A, Bronx, New York 10461. M.G.M. Medical College (India) 1970. Board eligible. Group, partnership, solo. Available July 1978.

Saad S. Antown, M.D., 1614 Union Turnpike, North Bergen 07047. Cairo 1964. Board eligible. Group, partnership, solo. Available July 1978.

Peter T. Nieh, M.D., 103 Locust Street, Burlington, Massachusetts 01803. Cornell 1973. Board eligible. Group or partnership. Available January 1979.

Areas in Need of Physicians

Borough of Raritan, Somerset County—For information communicate with Mr. Steve Del Rocco, Mayor, Borough Office, Raritan, New Jersey 08869.

Borough of South Bound Brook, Somerset County—For information communicate with Mr. Nicholas Rasnak, Borough Clerk, Municipal Hall, 12 Main Street, South Bound Brook, New Jersey 08880.

Township of Montgomery, Somerset County—For information communicate with Mr. J. Grey Jones, Jr., Mayor, Municipal Building, Route 206, R. D. #2, P.O. Box 1, Belle Mead 08502.

Borough of North Plainfield, Somerset County—For information communicate with Mr. Dean Tilesen, Borough Administrator, 263 Somerset Street, North Plainfield 07060.

Public Disclosure of Application for FDA Approval of New Drugs

April 25, 1978

Dear Dr. Krosnick:

I would like to call to your attention the *Federal Register* notice* of March 28, 1978. Please note that the Commissioner is proposing to make available to the public information on the existence of pending NDA's and IND's. At the present time, with a few exceptions, the Agency is forbidden to release such information. Thus, a practitioner who now writes the Agency and asks about an IND or an NDA (active research on a drug) will ordinarily not be given a substantive response.

Further, under current regulations, we cannot inform practitioners what new drugs are being researched for what diseases. Practitioners often state that this limits their ability to treat patients that are non-responsive to drugs currently on the market. The proposed change in regulations will correct these deficiencies. Often, however, proposals

*The following is quoted from the Federal Register of Tuesday, March 28, 1978: "(CFR Parts 312, 314, 431, 514, 601, 807, 814) (Docket No. 77N-0248) This proposal would amend existing regulations and promulgate new regulations to permit public disclosure of the existence and status of applications for approval of new drugs, new animal drugs, and medical devices pending before the Food and Drug Administration (FDA), and permit public acknowledgement of the existence of notices of intent to market medical devices. It would further amend the agency's public information and related regulations to permit the agency to respond truthfully and accurately to inquiries about the existence of applications for investigational notices for new drugs, new animal drugs, and medical devices when those notices have been approved by FDA or allowed to become effective."

†A communication was sent to the FDA by your Editor urging the Commissioner to amend the regulations to permit disclosure.

‡Persons desiring copies of the brochure may write directly to Norman Hymowitz, Ph.D., Department of Psychiatry, New Jersey Medical School, 100 Bergen St., Newark, New Jersey, 07103.

such as these receive so many negative comments that they are not implemented. This occurs because persons favoring such proposals often assume—incorrectly—that their comments are not needed.

Therefore, I urge you, as a fellow health professional, to write† the Hearing Clerk, Food and Drug Administration, 5600 Fishers Lane, Room 4-54, HFC-20, Rockville, Maryland 20857, by May 30, 1978 with your comments, favorable or unfavorable.

(signed) Alan S. Kaplan, M.D., M.P.H.

Euthanasia for Alcoholics?

May 12, 1978

Dear Dr. Krosnick:

I may become a regular contributor because of your provocative "Letters" column.

With regard to Dr. Strober's letter in the May 1978 issue (75:428-429), I can't agree (re Dr. Dock) that any "ideal internist" would practice euthanasia on unsuspecting alcoholics. I find Dock's comment interesting, because in my letter in the same issue I state that after the abortion decision "we can expect to move on to the next legislative plateau, which of course would include euthanasia."

Apparently Dr. Dock has been there—at Brigham, Stanford, Bellevue—long before me. I like Strober's attitude better.

(signed) Charles Harris, M.D.

Essex Anti-Smoking Committee

May 10, 1978

Dear Editor:

During the past year, the Essex County Heart Association Anti-Smoking Committee sponsored a number of activities to combat cigarette smoking.

Since cigarette smoking represents a major health hazard, there may be some merit in sharing with the readers of *The Journal* those activities which seem to hold the most promise for a favorable impact upon smoking cessation. Hopefully, others may include some of these activities in their own anti-smoking programs, while still others may come forward and share their experiences in the smoking cessation arena.

Two of our activities specifically were designed to increase the involvement of physicians in the smoking cessation process. As I noted in a recent article published in *The Journal*, the practicing physician may serve as an important source of referral for smoking treatment. Too often, the physician is unaware of available treatment programs. To facilitate the referral process, the Committee surveyed Essex County to determine who in the County offered smoking cessation treatment. A brochure‡ was produced and distributed to physicians in the county. Now, not only may physicians advise patients to stop smoking, they also may hand the patient the brochure and allow the patient to select the kind of treatment which best suits his/her needs.

A second activity involved the sponsorship of the First Annual Symposium on Cigarette Smoking for physicians and other health professionals. Featured speakers were Drs. Oscar Auerbach, Gio Gori, Ernest Wynder and Manning Feinlieb. They spoke on "the effects of cigarette smoking," "how to reduce the risk in the smoker," "community smoking cessation programs," and "the physician's role in smoking cessation," respectively. The symposium was well attended, and the speakers were favorably received. Ranking high among the suggested topics for the next symposium was the topic of techniques of smoking cessation.

Perhaps the most important activity of the Committee centers around the conduct of smoking cessation clinics in the community. Interestingly, the moderators for the clinics are non-professionals who are trained and

supervised by the Chairman of the Anti-Smoking Committee. The eight-week clinics include features such as behavior modification, group discussion, health education, and audiovisual presentations. Quit rates run high, ranging from 50-80 percent, and the clinics are available to high school students as well as adults. Hence, it is apparent that non-professionals, with some structure and supervision, can serve as effective agents of behavior change. We hope that a program will be developed to train and supervise more lay therapists from the community in the future. By so doing we expect to increase the number of concerned citizens engaged in anti-smoking activities.

(signed) Norman Hymowitz, Ph.D.

"Minority" (?) Opinion

May 22, 1978

Dear Editor:

Reflecting on the lack of accomplishment of the 212th Annual Meeting of MSNJ, I feel "compelled" by conscience to avail myself of *The Journal* to enlighten the general membership regarding the proceedings.

It is my contention that my views represent the feelings of a vast majority of MSNJ's membership. Those views, essentially are that our professional and private lives are being grossly over-regulated. The government is the prime offender, but "organized medicine" is now becoming a party to that intrusion, and adding regulations of its own. All of this interference is extremely costly, rarely cost-effective, and frequently detrimental to quality care. The worst feature is that we are being projected as the cause of this fiasco, rather than its victims. In a misguided effort to retain our steadily deteriorating "image," our leadership consistently refuses to take any action that might be interpreted as being in our self-interest.

Originally, MSNJ was formed by a group of ethical faith healers, to protect themselves and their patients from the "quacks." With subsequent medical progress, it became a respected scientific and social society. The advent of Politicized Medicine has mandated a return to that historical protective function.

We are in dire need of some action to oppose the tidal wave of bureaucratic intrusion that must eventually inundate us. No such action is forthcoming.

Two years ago, I accused the House

of Delegates of favoring nothing more controversial than motherhood and apple pie. Last year, I observed that, since motherhood and apple pie had been declared hazardous to health by the FDA, we would be hard pressed to endorse anything.

In keeping with this non-controversial posture, the Governor's Conference, which the Governor did not see fit to attend, became a forum for joining our bureaucratic brethren in opposing cancer.

With a minimum of discussion, the House endorsed the following: 1. Marijuana can be harmful. 2. "Impaired physicians" should be repaired or replaced. 3. Hospices would provide a dignified homelike atmosphere for our therapeutic failures to die in, without being a burden to their families. 4. Cozy Morley's Wing Ding should be replaced by the Entertainment Committee. 5. More regulations for the segregation or elimination of smokers and smoking in public and private places. (The philosophical inconsistency, in this case, didn't seem worth the time and effort of active opposition.)

Handling of the "controversial" issues should have qualified for CME credits in Medical Politics. The big three, to me, were:

1. *Mandatory AMA membership.* This action, overwhelmingly rejected by the general membership several years ago, rejected by the Reference Committee and the majority of those testifying before it, was passed by a nineteen vote margin on the House floor. I feel that this measure is divisive and detrimental to MSNJ. The two-thirds majority needed to amend the Constitution is most unlikely. The valuable time, already lost to this issue, and that to be spent on it in coming months, could have been far better directed elsewhere. The silver lining to this cloud is the certainty that a proposed \$250 assessment will serve to "activate" some of our silent majority.

2. *Support of AMA's HR 1818.* Since seven other States had already seen fit to reevaluate and withdraw their support of this endorsement of National Health Insurance, I had proposed a resolution to withdraw our support. The intent was to discuss this very timely issue on the floor of the House, and formulate a position for our Delegates to the upcoming AMA Convention. Discussion in the Reference Committee was reasonably divided. Discussion by the House was precluded by a clever

tactical move. The Resolution was referred to the Board of Trustees for their recommendation. Since that recommendation was not forthcoming at this session, any eventual action by the House would be after-the-fact and meaningless. Such procrastination explains our ineffectiveness.

3. *AMA Committee on Cost Containment.* Though much time was spent on this subject, there was no possibility of adequately addressing all the implications of the 48 recommendations of the Committee. What was open to discussion was the overall implication that doctors held the key to cost containment, and the adverse PR effects of that impression.

Two "Emergency Resolutions" regarding this matter were rejected, leaving only the Resolution that I had the foresight, from past experience, to submit through the "proper" channels. This Resolution proposed to lay the major blame for cost escalation where it belonged; on Government spending and intrusion, and to *direct our PR efforts* toward informing the public of the costs of current and proposed Governmental intervention. After several efforts to divert or dilute this proposal, it reached the floor of the House. A fairly lively battle evolved, but ultimately WE WON.

In the face of such adversity, I am proud of my .333 batting average. One out of three ain't bad. What remains to be seen is whether our PR efforts implement the instructions of the Resolution. All members should voice their concern, if there is no compliance.

4. *Emergency Resolution #22.* This represented a proposal for action from a hard working Committee, which conceded that it was far from the perfect solution to the problem. Since it recommended a procedure that I already voluntarily follow, and could serve to focus attention on the inequities of the Medicaid program, I supported this measure. After the customary attempts at dilution and diversion, it survived. I have little hope for its effectiveness, since it relies on a unity of purpose that this Society has yet to demonstrate.

Time is running out on Private Practice and Private Citizenship. If you are not satisfied with MSNJ's actions and inactions, get involved, at least on a county level. Too many members suffer from an apathy bred of impotence. I was congratulated by many people at the Annual Meeting for having the courage to say what needed to be said. I am

convinced that, almost singlehandedly, I had effective input. Imagine what we might accomplish if the rest of you took the time and effort to express your viewpoint, and replaced my solo with a chorus.

My friends and detractors seemed to share an appreciation for the bumper sticker that I distributed at the meeting. It read:

WARNING:

Government Intrusion
Can Be Hazardous to Your Health

(signed) Frank J. Primich, M.D.

Screening for Colo-rectal Cancer

May 23, 1978

Dear Editor:

Considering the large number of newly diagnosed cases of colon rectal cancer in this state every year (46,000 expected in 1978), it is surprising that so many patients have managed to enter seventh and even eighth decades of life without ever having a Hemoccult® test or sigmoidoscopy as screening procedures.

The demonstrated lack of improvement in our salvage rate for colo-rectal cancer over the past 30 years clearly has emphasized the need for earlier diag-

nosis, as fully one-third of these cases already have visceral metastasis when seen for the first time.

It would seem appropriate for all practitioners in this state to incorporate routine examination of the stool for blood and sigmoidoscopic examination as part of the annual examination on their patients. This should be as important as the annual Pap smear is for female patients.

Recent screening of large populations by cancer detection centers clearly has proved the efficacy of these methods in detection of early and highly curable lesions by these methods. The technology is with us, so let us make use of it.

(signed) Michael S. Slade, M.D.

CME INFORMATION

Conference on Primary Care of Hand Injuries

The American Society for Surgery of the Hand will sponsor a four-day conference on primary care of hand injuries, September 29 through October 1 at The Cloister, Sea Island, Georgia. Designed for physicians who treat acute hand trauma—emergency room physicians, general practitioners, orthopedic, plastic, and general surgeons—the course is geared to physicians who have not had formal training in surgery of the hand. Functional anatomy, general principles of wound treatment, and specific injuries are emphasized. Included will be lectures, workshops, round table discussions, and small group sessions. Topics include anatomy and general principles, integument and nerves, skeletal system, tendons and burns, rationale for reconstruction, and others. Tuition is \$250 (\$100 for residents who have a letter from their institution). Twenty-four credits will be awarded in category I of the AMA Physician's Recognition Award. Application has been made for credit hours with the American College of Emergency Physicians and the American Academy of Family Practice. For additional information please communicate with Gail M. Gorman, Administrative Director, American Society for Surgery of the Hand, 2600 South Park Road, Room 233, Aurora, Colorado 80014. (303) 755-4588).

Cancer Chemotherapy Symposium

On October 27 and 28 the Mount Sinai Medical Center, New York, is sponsoring a chemotherapy symposium entitled "New Developments and Changing Concepts in Cancer Chemotherapy." The program has been arranged by the Division of Medical Oncology, Department of Medicine, the Department of Neoplastic Diseases, and the Postgraduate School of Medicine of Mount Sinai School of Medicine. For registration and information, please communicate with Dr. Ezra M. Green-span, Chairman, at the Postgraduate School, Mount Sinai School of Medicine, One Gustave L. Levy Place, New York 10029.

Workshop on Thyroid Disease

The American Thyroid Association is sponsoring a workshop on thyroid disease, November 5 to 7, at the Copley Plaza Hotel in Boston. This two-day program is designed for physicians in internal medicine, family practice, surgery, and obstetrics who do not have subspecialty training in the field of thyroidology. There will be a syllabus, lectures will be offered, small group discussions will be held, and physicians

will participate in self-administered quizzes. For additional information on the program and registration, please write to WT Registration, Center for Continuing Education, 1307 East 60th Street, Chicago, Illinois 60637. Further information also can be obtained from Dr. P. Reed Larsen, Peter Bent Brigham Hospital, 721 Huntington Avenue, Boston, Massachusetts 02115.

Diagnostic Radiology

From February 12 through 16, 1979, at the Princess Hotel in Acapulco, Mexico, the Department of Radiology of Duke University Medical Center will present a graduate course in diagnostic radiology including ultrasound and CT scanning. Registration fee is \$250; \$125 for those in training if the application is accompanied by a letter from the chairman of the department in which the trainee is studying. Thirty credit hours will be awarded in Category I of the AMA Physician's Recognition Award. For further information, address an inquiry to Robert McLelland, M.D., Radiology—Box 3808, Duke University Medical Center, Durham, North Carolina 27710, telephone (919) 684-4397 or 2711.

CME CALENDAR

This listing is compiled through the cooperation of the Committee on Medical Education of the Medical Society of New Jersey, the Academy of Medicine of New Jersey, the New Jersey Chapter of the American Academy of Family Physicians, and the Office of Continuing Medical Education of the College of Medicine and Dentistry of New Jersey. For information on accreditation, please contact the sponsoring organization(s), indicated by italics—last line of each item.

July

- 12 Introduction to Family Therapy**
- 19** 3-5 p.m.—Fair Oaks Hospital, Summit
- 26** (*Fair Oaks Hospital and AMNJ*)

Aug.

- 21- Basic Life Support Certification Course**
- 25** 12 noon-1 p.m.—Walson Army Hospital Fort Dix
- (*Walson Army Hospital and AMNJ*)

Sept.

- 6 Continuing Education in Psychiatry**
- 1-3 p.m.—Bergen Pines County Hospital Paramus
- (*Bergen Pines Hospital and AMNJ*)
- 7- 4th Memorial Ignatz Semmelweis**
- 11 Seminar**
- Playboy Club, Great Gorge, New Jersey
- (*New Jersey Medical School, AMNJ, and AAFP*)

- 12 Surgical Lecture—Motor Disorders of the Esophagus**
- 5-6 p.m.—Rutgers Medical School Piscataway
- (*CMDNJ and AMNJ*)
- 15 Heart Disease in the Neonate**
- 8:15 a.m.-10:30 a.m.—Overlook Hospital, Summit
- (*Overlook Hospital and AMNJ*)
- 27 Preventive Medicine in the Elderly**
- 1-2 p.m.—VA Hospital, Lyons
- (*VA Hospital and AMNJ*)

Oct.

- 3 Complications of Vascular Surgery**
- 5-6 p.m.—Rutgers Medical School Piscataway
- (*CMDNJ and AMNJ*)
- 3- Clinical/Histopathological Overview of**
- 7 Obstetrics/Gynecology**
- Begins Oct. 3-9 a.m.—Waldorf Astoria New York
- (*St. Barbabas Medical Center and AMNJ*)
- 4 Continuing Education in Psychiatry**
- 11** 1-3 p.m.—Bergen Pines County Hospital
- 18** (*Bergen Pines Hospital and AMNJ*)
- 25**
- 20 Recent Advances in Perinatology**
- 8:15-10:30 a.m.—Overlook Hospital Summit
- (*Overlook Hospital and AMNJ*)

Nov.

- 1 Continuing Education in Psychiatry**
- 8** 1-3 p.m.—Bergen Pines County Hospital Paramus
- 22** (*Bergen Pines Hospital and AMNJ*)
- 7 An In-Depth View of the Vagus**
- 5-6 p.m.—Rutgers Medical School Piscataway
- (*CMDNJ and AMNJ*)
- 15 Recent Advances in Gastroenterology**
- 9 a.m.-5 p.m.—VA Hospital East Orange
- (*VA Hospital and AMNJ*)
- 17 Recent Advances in Genetic Diagnosis and Counseling**
- 8:15-10:30 a.m.—Overlook Hospital Summit
- (*Overlook Hospital and AMNJ*)

Dec.

- 5 Colo-rectal Carcinoma**
- 5-6 p.m.—Rutgers Medical School Piscataway
- (*CMDNJ and AMNJ*)
- 6 Continuing Education in Psychiatry**
- 13** 1-3 p.m.—Bergen Pines County Hospital
- 20** Paramus
- 27** (*Bergen Pines Hospital and AMNJ*)
- 15 Management of the Juvenile Diabetic**
- 8:15-10:30 a.m.—Overlook Hospital Summit
- (*Overlook Hospital and AMNJ*)

OBITUARIES

Dr. Max Block

On April 29, Max Block, M.D., a well-known Montclair internist, died in Community Hospital there. Born in New York City, Dr. Block earned his medical degree from Vanderbilt University School of Medicine in 1931, and following residencies in internal medicine and cardiology at Montefiore Hospital in New York City, he established a practice in Montclair which he maintained until his death. He was a Fellow of the American College of Car-

diology and of the American College of Angiology, and had been chief of medicine and chairman of the department of cardiology at Montclair Community Hospital. Dr. Block was a member of the American Society of Internal Medicine, the American Heart Association, and the Academy of Medicine of New Jersey. He was the author of several articles in his field. He also was active in community affairs and had been physician for the Montclair Board of Education for many years. Dr. Block was 73 years old at the time of his death.

Dr. Floyd D. Hunter

Floyd D. Hunter, M.D., a member of our Mercer County component, died on May 4 in Hamilton Hospital after a short illness. Born in Illinois in 1904 and graduated from the University of Louisville Medical School in 1930, Dr. Hunter was a general practitioner in Hamilton Square for 46 years. He was on the staff at the Mercer Medical Center and at the Hamilton Hospital in Trenton. In 1977 he was honored at a testimonial dinner noting the many years as a devoted phy-

sician in his community. During World War II Dr. Hunter served with the Army of the United States as a surgeon with the 93rd evacuation hospital in North Africa and Europe.

Dr. Samuel R. Kesselman

On May 11, Samuel R. Kesselman, M.D., a Newark neuro-psychiatrist, died in Beth Israel Medical Center. A native of New Jersey, born in 1914, Dr. Kesselman earned his medical degree from Cincinnati Eclectic Medical College in 1939 and pursued graduate work in neurology and psychiatry at Brooklyn State Hospital, becoming board certified in those specialties. He was a neuro-psychiatrist for the State Reformatory at Rahway, in addition to having a private practice in Newark where he was affiliated with Martland and Beth Israel Medical Centers. He was a member of the American Psychiatric Society, the International Congress of Psychiatry, and the Academy of Medicine of New Jersey. During World War II, Dr. Kesselman served with the Army of the United States, mostly in the Pacific.

Dr. Alice B. Lewis

Word has been received of the death on April 30 of Alice B. Lewis, M.D., a member of our Bergen County component. A graduate of New York Medical College for Women in 1914, Dr. Lewis practiced obstetrics and gynecology in Hohokus for many years before retiring to Neptune in 1962 where she was living at the time of her death.

Dr. James H. Mason, III

One of Atlantic County's prominent senior physicians, James H. Mason, III, M.D., died suddenly at Atlantic County

Medical Center on May 9. A graduate of Jefferson Medical College, class of 1918, Dr. Mason had practiced in the Atlantic County area since 1920. He was a board certified surgeon and a Fellow of the American College of Surgeons and had been surgical chief at the Atlantic City Hospital for many years, retiring from active practice in 1963. He was a member of the prestigious New Jersey Society of Surgeons, of which he was a past president. Dr. Mason participated in medical society affairs and had been president of his county medical society. He was interested in his community and was an active member of many boards of directors of civic organizations. He was 84 years old at the time of his death.

George J. McKeon

At the untimely age of 53, George J. McKeon, M.D., died on May 5 while vacationing in Ireland. Born in New York City, Dr. McKeon was graduated from the University of Dublin Medical School in 1956 and returned to New York for internship and residency in general practice. He was a member of our Atlantic County component and had practiced in Somers Point for 19 years, serving on the staff of the Shore Memorial Hospital there.

Dr. E. Raymond O'Brian

E. Raymond O'Brian, M.D., a member of our Union County component, died after a short illness on April 16. Dr. O'Brian was born in Baltimore in 1916 and received his medical degree from New York Medical College, class of 1943. He pursued graduate work in pediatrics and became board certified in

that specialty. He was a Fellow of the American Academy of Pediatrics, a member of its New Jersey Chapter, and had been attending pediatrician at the Muhlenberg Hospital in Plainfield. During World War II Dr. O'Brian served in the department of medicine of the Army of the United States.

Dr. Michael Rachunis

On May 2, Michael L. Rachunis, M.D., a member of our Burlington County component, died at the Rancocas Valley Hospital, Willingboro. Dr. Rachunis was graduated from Jefferson Medical College in 1936, and following graduate work at Polyclinic Hospital and Columbia Medical Center in New York, he established a practice in ophthalmology and otolaryngology, first in Glen Lyon, Pennsylvania and for the past 29 years in Burlington, retiring in 1971. Dr. Rachunis had been on the staff at Rancocas Valley Hospital.

Dr. Max L. Weimann

Notice has just been received of the death on February 15 of Max L. Weimann, M.D., of Camden County. A graduate of Jefferson Medical College in 1927, Dr. Weimann took graduate studies in pediatrics and established a practice in that field in Haddon Heights, where he remained until retirement in 1974. Dr. Weimann was board certified in his chosen specialty and a Fellow of the American Academy of Pediatrics. He had been affiliated with Cooper Hospital in Camden and in Philadelphia with Children's and Jefferson Hospitals.

Acupuncture: Science or Charlatanism?

Cesar Mishaan Pinto, M.D. Ardmore, Pa., Dorrance & Company, 1978. Pp. 441. Illustrated. (\$14.95)

This is an interesting text by an American-trained surgeon practicing in Guatemala. He attempts to provide a scientific rationale for the use of acupuncture but makes the naïve assumption that because the so-called points and meridians have been in use in the Orient for five thousand years they are specific identifiable anatomic entities.

Dr. Pinto then propounds a new theory that the points of acupuncture are accretions of thin-walled lymphatic vessels at the intersection of major lymphatic pathways and that their penetration by the acupuncture needle allows the introduction of microbubbles of air whose travels via meridians alter enzymatic and metabolic functions remote from the site of entry. He attempts to buttress this theory with anatomical details designed to prove that internal organs have a direct con-

nection with skin points via long meridians, but the facts appear to be speculative fantasy with little experimental data base. The theory is intriguing, but, in the opinion of this reviewer, remains just another theory.

The remainder of the book is filled with excellent charts showing in great detail the classic points and meridians of the acupuncturist for those who might wish to try out the technique themselves even though it is difficult to accept in modern medicine a chart showing the points necessary for treatment of cirrhosis of the liver, tetanus, or typhoid fever.

L. D. Policoff, M.D.

Mealtime Manual for People with Disabilities and the Aging

Prepared by Institute of Rehabilitation Medicine, NYU Medical Center, and Campbell Soup Company. Camden, New Jersey, Campbell Soup Company, 1978. Pp. 269. Illustrated. (\$3.25)

This is an excellent manual demonstrating techniques which can make it possible for a handicapped homemaker to function efficiently in food preparation. It does not stop there, however, but provides helpful hints on the purchase of appliances, on shopping, on planning meals and menus for optimal nutrition and even on the modifications in food preparation that will work best "when you are alone." There are chapters of helpful advice for the handicapped who work with one hand, who have arthritis, who have no coordination, who use a wheelchair, and so on.

A host of adaptive devices for increasing safety and efficiency in the kitchen are described and well illustrated with good photographs. Sources for obtaining special devices and appliances are detailed.

The manual is a useful compendium of information for the handicapped patient, young or old, and for the physician and health care team who look after such patients.

L. D. Policoff, M.D.

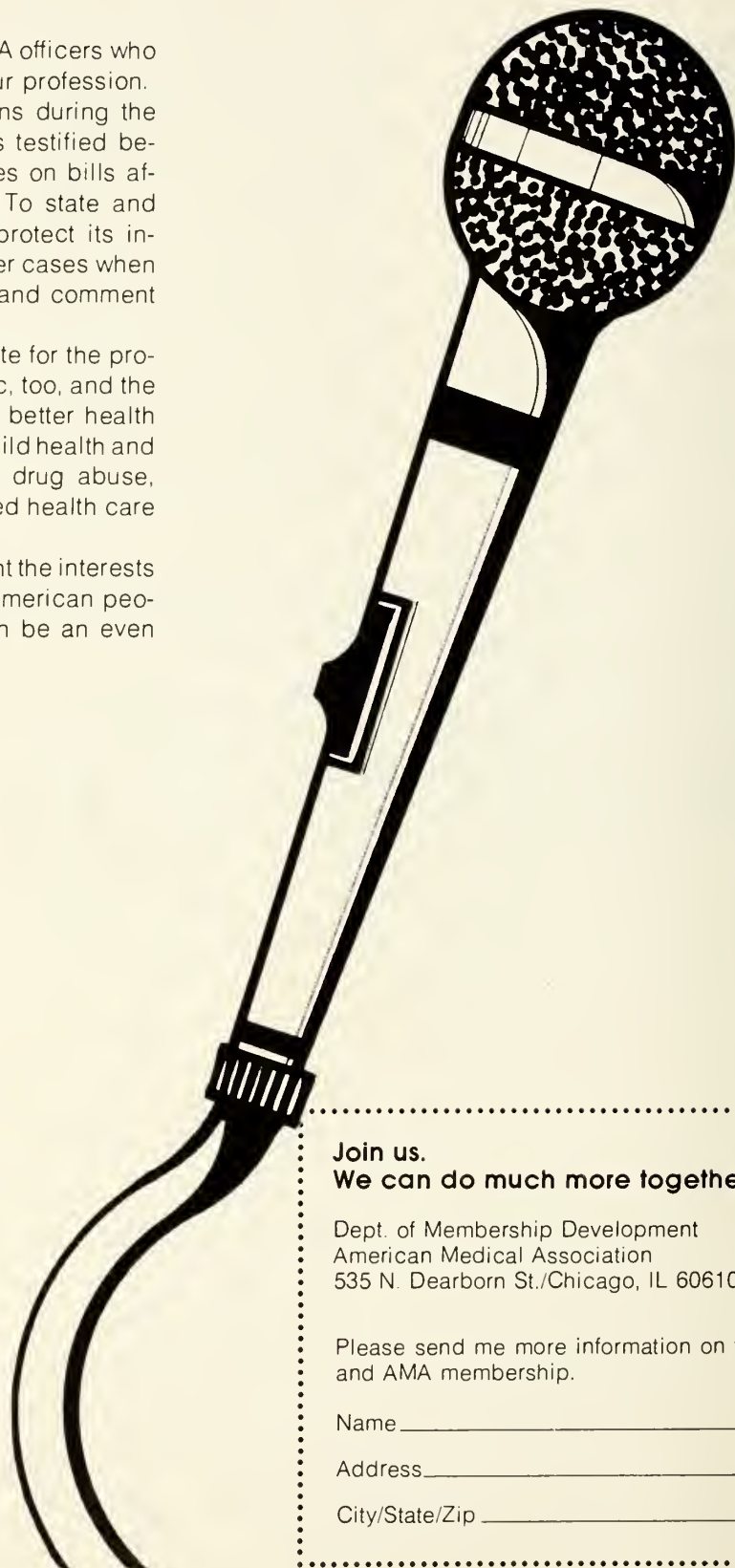
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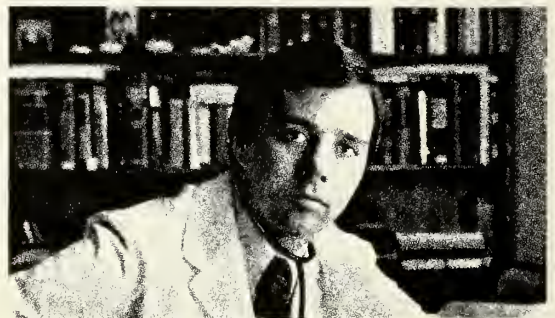
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Date: Wednesdays, 9-11 a.m., Starting September 20, 1978 and ending May 23, 1979.

Beginning this September and ending May 23, 1979, the Postgraduate Course "Recent Advances in Internal Medicine and Therapeutics" will be given as in previous years at Middlesex General Hospital in New Brunswick. The 34 sessions of the Course are approved for 68 Category I AAFP credits and for 68 hours of the continuing education requirement of the Medical Society of New Jersey and the Physicians Recognition Award of the AMA.

As in previous years, the 23rd year of the Course is designed to provide clear and concise reviews of important advances in Internal Medicine that are of practical interest to primary physicians and internists in family practice. All 34 of the two-hour Wednesday morning sessions are conducted by outstanding physicians of the medical faculties of New York, Boston, Philadelphia and other metropolitan centers. During the sessions opportunity is given to discuss with the speakers aspects of clinical problems that arise in the care of individual patients. The 1978-1979 Series will be devoted to discussion of Circulatory Disorders, Neuropsychiatry, Endocrinology and Metabolism, Gastrointestinal Disorders, Urogenital Disorders, Infectious Disease, and other subjects. The opening session is set for Wednesday, September 20, 1978.

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August 1978

Journal of
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The Medical Society of New Jersey Journal

New Jersey

New Jersey
ACP Papers

Rev. Stephen Hales
Harry Bloch, M.D.

Screening for Endometrial
Carcinoma
V. V. Gowda, M.D.
J. Apuzzio, M.D.

Interdigital Sinuses of
Barbers' Hands
J. R. Donahue, et al.

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- Oct. 18-Dec. 20** **CONSULTATIONS IN INTERNAL MEDICINE** **Fee: \$350**
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- Oct. 19-20** **SHERLOCKIAN DERMATOPATHOLOGY** **Fee: \$225**
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- Oct. 21-22** **ROBERT S. HOTCHKISS SYMPOSIUM—MALE INFERTILITY** **Fee: \$200**
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- December 2-3** **PRACTICUM IN PSYCHIATRY & THE CRIMINAL LAW** **Fee: \$160**
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- Dec. 7-8** **DIAGNOSIS OF MUSCULAR DISEASES** **Fee: \$160**
Intensive practical review of essential methodology and advanced techniques in the diagnosis of neuromuscular diseases for neurologists, neurophysiologists and physiatrists. (14 hours AMA Cat. I)
- Dec. 11-12** **CLINICAL ELECTRODIAGNOSIS OF NEUROMUSCULAR DISEASES** **Fee: \$160**
Presents advanced and unusual techniques of electromyography and nerve stimulation studies. For clinical neurophysiologists, neurologists, neurosurgeons, orthopedists and physiatrists. (14 hours AMA Cat. I)
- Dec. 9-10** **PSYCHIATRY FOR PRIMARY CARE PHYSICIANS** **Fee: \$185**
Identification and management of crisis and emergency situations in office practice: depression, anxiety attacks, acute psychotic states, hysteria, psychosomatic complaints, suicide threats and drug abuse. Guidelines for using common psychoactive drugs. (14 hours AMA Cat. I; AAFP prescribed hours)
- Dec. 11-15** **NEUROSURGERY/NEW YORK CITY 1978** **Fee: \$385**
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- Jan. 3-May 30, 1979** **INTERNAL MEDICINE—AN IN-DEPTH REVIEW** **Fee: \$500**
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- INFORMATION:** Fees and dates subject to change. For information or course brochure, write or phone: Registration Dept., NYU Post-Graduate Medical School, 550 First Avenue, New York, NY 10016. 212-679-8745 (24 hr. telephone)

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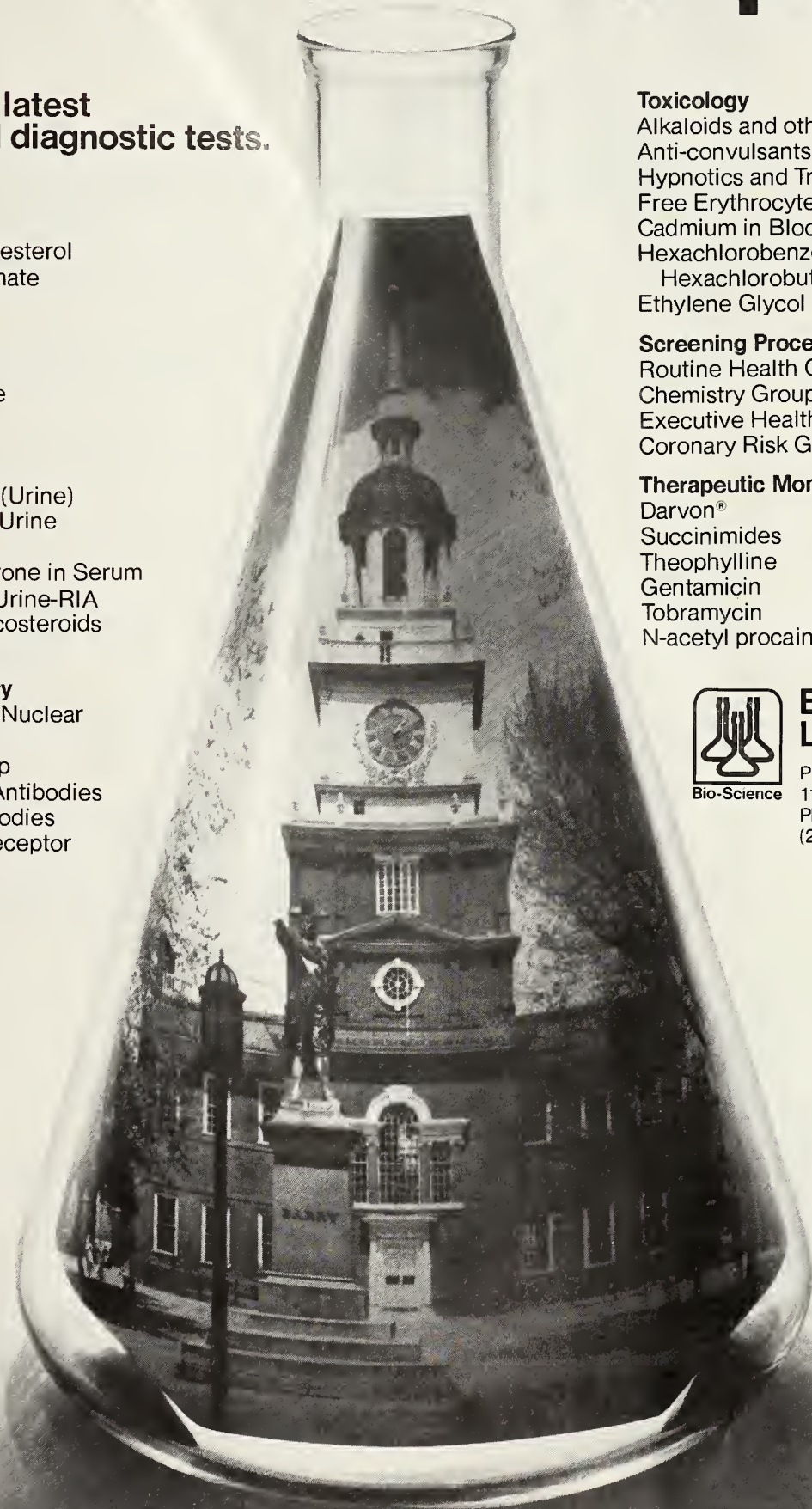
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Cover Photo

The photograph of Barnegat Light on the Jersey shore, used for this month's cover, was provided by Richard Musgnug, M.D., a dermatologist from Cherry Hill, who is a member of MSNJ's Committee on Environmental Health. He has won citations both nationally and locally for his nature photography. Dr. Musgnug also supplied the picture of the beach scene used on the July Transactions cover.

DESCRIPTION: Methyltestosterone is 17 β -Hydroxy-17-Methylandrosta-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunuchism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric,

avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE**

REACTIONS: Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. In the male: Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioglu, M.D.: Hormones for Improved Sexuality in the Male and the Female Climacteric. *Drug Therapy*, Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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Continuing Medical Education (CME)

Continuing Medical Education in New Jersey has been with us for a long time but, like Harriet Beecher Stowe's Topsy, it just "grow'd."** To date we have accepted it as a fact of life, but CME has major problems. Among them consider whether, as some have said, the cost/benefit ratio of CME is unfavorable:

"Although large amounts of money are spent nationally on CME, the net effect is uneconomic, particularly in research and development of CME."**

In any case, a close look at CME, as it presently exists, is necessary.

WHY CME?

The reasons for CME—and the motivation for physician participation—have changed. Originally we had an internal desire to learn, to replace archaic knowledge as new information and skills arise, and to provide the best medical and surgical care to patients. As time passed and government programs grew, there appeared an implied threat that failure to participate in post-graduate education experiences might lead to delicensure. Thus, a peer-controlled institutional pressure was added. This required physician participation in CME in order to maintain membership in national organizations such as the American Academy of Family Physicians and the AMA. Physicians then were obligated to document their involvement in learning experiences sponsored or conducted by recognized authorities or organizations. This requirement presently is a problem in our state for some 582 MSNJ members who did not comply with the mandate to acquire 150 hours of CME credits in a three-year period of time by the original deadline; their membership now is in jeopardy.

Among the new reasons for CME besides internal motivation and peer pressure are economic inducements. The availability of fiberoptic endoscopes, ultrasound equipment for hospital and office use, special equipment for non-invasive evaluation of vascular function, and devices for cardiac-stress testing have prompted some physicians to learn and incorporate such remunerative techniques into their practices.

One might consider the wave of enthusiasm among specialty organizations and specialty boards to push for recertification as another form of institutional pressure for CME. The ultimate coercion may be the recent announcement that the New Jersey Board of Medical Examiners is "planning" to require physicians to participate in CME in order to retain licensure. Tagged to this in the future might be the problem of malpractice and professional liability insurance. The issue of such insurance some day may be restricted to those who have satisfied CME requirements and have passed recertification/relicensure examinations.

EXISTING CME

We all are familiar with the present approach to CME, which is a hodgepodge of techniques. These include grand rounds, CPC's, workshops, visiting lecturers, courses, and symposia. They are sponsored by hospital staffs, medical organizations (county, state, and national medical societies, specialty societies), the College of Medicine and Dentistry of New Jersey, the Academy of Medicine of New Jersey, a variety of voluntary and official (state and federal) health agencies, and numerous pharmaceutical companies.

In addition to "live" CME programs, there has been an avalanche of printed courses, with or without cassette tapes, national closed-circuit television panels, teaching machine and computer-assisted programs, a variety of audio-visual and mixed media presentations, and even video-taped lectures and panels for home use. Many of these encompass a self-assessment feature. Even medical journals contain sections for CME credit.

PROBLEMS WITH CME

How does a physician select a CME experience from among the infinite variety of choices? It is very difficult because of the lack of coordination among the sources and sponsors. At present the content of CME largely is derived from the self-interest of the sponsors rather than the needs of the physician. Thus, a manufacturer of oral hypoglycemic drugs is pleased to fund a CME program on such drugs, but the lecturers generally come from a corporate-prepared speakers' bureau made up of professionals who are favorably inclined toward their products. This means that some areas of medical information get saturation-coverage, while others are neglected. Because of the dollar value of sales, antibiotics, antihypertensive drugs, diuretics, and psychotropic medications are extremely popular CME topics. Some physicians select programs based on the day of the week (Wednesday and Thursday are very popular in New Jersey) and location (either right in town or at some exotic distant location such as Las Vegas or San Francisco, and presumably Atlantic City in the near future).

The constraints imposed by some sponsors, which may be based on market forces, may indeed inhibit CME content. In view of these factors, and the variety of sources of funds for CME programs, there is no wonder that a coordinated approach is impossible with our present non-system.

It is axiomatic that *needs-assessment* should be the basic

*The little slave girl in *Uncle Tom's Cabin* maintained that she had neither father nor mother. Her answer to Aunt Ophelia's question about her origin was "I 'spect I just grow'd."

**Competence in the medical professions: A strategy. DHEW Publication No. (HRA) 77-35, p. 13.

factor which determines course content, yet this concept virtually is ignored. In view of the explosion of scientific information in recent decades, this concept becomes more critical than ever. The most disturbing factor of all about CME is that there is very little objective evidence that exposure to CME, as presently constituted, results in a favorable change in practice habits by physicians.

FUTURE DIRECTIONS IN CME

The first priority in New Jersey should be the establishment of a *statewide, pre-planned system of continuing medical education*. The basic sponsors of New Jersey CME might be the College of Medicine and Dentistry of New Jersey, the Medical Society of New Jersey, the Academy of Medicine of New Jersey, and the New Jersey State Departments of Health and Higher Education. Additional partners and advisors to this educational conglomerate may come from the New Jersey Academy of Family Practice, the New Jersey Osteopathic Association, the State Board of Medical Examiners, and various specialty organizations (ACS, ACP, and so on).

A prime requisite of such a systematized program should be a base of operations such as an *Institute for Continuing Medical Education* (ICME). Ideally, this would be located in an academic setting such as the campus of the College of Medicine and Dentistry of New Jersey or at the site of the new Medical Society of New Jersey's headquarters (which, it is anticipated, also will house the New Jersey Academy of Medicine). The ICME could invoke the principle of individual physician and group needs-assessment as the basis for CME with curriculum content based on demonstrated needs rather than marketability. Through a clearinghouse technique, the ICME would be able to coordinate course development. A novelty would be its ability to encourage research in evaluation, basic course design and development, and objective needs-assessment.

At present the bulk of funding of CME in New Jersey comes from participants' fees and from special interest groups, but it is time for a change. Since government and foundations are clamoring for maintenance of professional competence and for quality health care, and since they include CME, recertification and relicensure among their tenets, the time has come for *them* to invest sizable dollar sums into organized CME based on a clearly defined policy. They now must consider CME *at least as important as undergraduate medical education*.

A prime asset of the institute would be a "*State of the Art*" learning center to which physicians might come for intensive instruction. Such a center could invite practitioners to spend a day, a week, or an "educational sabbatical" of several months in an environment conducive to learning. An ICME learning center could recall CMDNJ graduates periodically for an educational refueling. It also could utilize the *opinion leader concept*, which identifies and strengthens the consulting specialists and subspecialists in each community. These physicians not only care for patients but also educate their colleagues. The learning center could embellish the positive aspects of existing mini-residencies as well as the CMDNJ preceptor program. Among the newer education techniques, "simulation," using computers or programmed actors, would be a natural inclusion. The ICME could become the educational bank for development and dissemination of innovative educational materials and techniques.

SUMMARY

It is time for CME in New Jersey to take shape. We need a definite, definable system. An Institute for Continuing Medical Education (ICME), funded by public and private (foundation) money, should be the base of operations for such a system of CME.

A.K.

An Occupational Disorder

At a recent scientific symposium, your editor observed a phenomenon which is all too familiar. As speakers asked for the first slide, nothing happened. When slides finally began to appear, after much shouting and signaling, some were upside down, others were reversed horizontally, and the last slide was shown first. When the speaker asked for "slides off, lights on" the slide remained on and the hall was kept in darkness. Once more, it required hand-waving and shouting to obtain the requested action.

A promotional film narrated by former President Gerald Ford was shown to two different audiences. On each occasion, the voice and lips were not synchronized and our esteemed ex-leader sounded like "Gravel Gertie."

One had to wonder why this never-ending phenomenon has persisted—at least since the slide projector was invented. The easy answer is "The Peter Principle," but that seemed too convenient.

After much diagnostic introspection, the problem finally became all too clear. It appears that slide and film projectionists for medical meetings suffer an occupational disorder affecting various portions of the sensory and central nervous systems. It includes selective hearing loss,

intermittent amaurosis, the periodic inability to tell the top from the bottom, and—most interestingly—a transient failure to discriminate left from right.

Having known some of these individuals personally, it is strange that they seem to suffer this malady only in auditoria filled with physicians. The victims of this disorder tend to be young males and union members.

They seem to have an intrinsic need for disorder. A carefully arranged pile of slides, numbered from one to fourteen always starts with slide number three or five when they appear on the screen. The propensity for darkness when no slides are being shown suggests insecurity and a desire for anonymity.

This problem is clearly an occupational disorder of undetermined etiology. It involves a dysfunction of certain centers in the sensory and central nervous systems and appears to be perennial, untreatable, and benign.

For completeness, we need a name for this condition and, rather unimaginatively, one might call it the Slide Projectionists's Syndrome (S.P.S.) until research into the matter provides us with a pathophysiologic explanation which can be formulated into a suitable diagnosis.

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Important Note: When it is judged necessary that treatment be initiated before definitive culture and sensitivity results are known, the choice of cloxacillin sodium should take into consideration the fact that it has been shown to be effective only in the treatment of infections caused by pneumococci, Group A beta-hemolytic streptococci, and penicillin G-resistant and penicillin G-sensitive staphylococci. If the bacteriology report later indicates the infection is due to an organism other than a penicillin G-resistant staphylococcus sensitive to cloxacillin sodium, the physician is advised to continue therapy with a drug other than cloxacillin sodium or any other penicillinase-resistant semi-synthetic penicillin.

Recent studies have reported that the percentage of staphylococcal isolates resistant to penicillin G outside the hospital is increasing, approximating the high percentage of resistant staphylococcal isolates found in the hospital. For this reason, it is recommended that a penicillinase-resistant penicillin be used as initial therapy for any suspected staphylococcal infection until culture and sensitivity results are known.

Cloxacillin sodium is a compound that acts through a mechanism similar to that of methicillin against penicillin G-resistant staphylococci. Strains of staphylococci resistant to methicillin have existed in nature and it is known that the number of these strains reported has been increasing. Such strains of staphylococci have been capable of producing serious disease, in some instances resulting in fatality. Because of this, there is concern that widespread use of the penicillinase-resistant penicillins may result in the appearance of an increasing number of staphylococcal strains which are resistant to these penicillins.

Methicillin-resistant strains are almost always resistant to all other penicillinase-resistant penicillins (cross-resistance with cephalosporin derivatives also occurs frequently). Resistance to any penicillinase-resistant penicillin should be interpreted as evidence of clinical resistance to all, in spite of the fact that minor variations in *in vitro* sensitivity may be encountered when more than one penicillinase-resistant penicillin is tested against the same strain of staphylococcus.

Contraindications: A history of a previous hypersensitivity reaction to any of the penicillins is a contraindication. **Warning:** Serious and occasionally fatal hypersensitivity (anaphylactoid) reactions have been reported in patients on penicillin therapy. Although anaphylaxis is more frequent following parenteral therapy it has occurred in patients on oral penicillins. These reactions are more apt to occur in individuals with a history of sensitivity to multiple allergens.

There have been well documented reports of individuals with a history of penicillin hypersensitivity reactions who have experienced severe hypersensitivity reactions when treated with a cephalosporin. Before therapy with a penicillin, careful inquiry should be made concerning previous hypersensitivity reactions to penicillins, cephalosporins, and other allergens. If an allergic reaction occurs, the drug should be discontinued and the patient treated with the usual agents, e.g., pressor amines, antihistamines, and corticosteroids.

Safety for use in pregnancy has not been established.

Precautions: The possibility of the occurrence of superinfections with mycotic organisms or other pathogens should be kept in mind when using this compound, as with other antibiotics. If superinfection occurs during therapy, appropriate measures should be taken.

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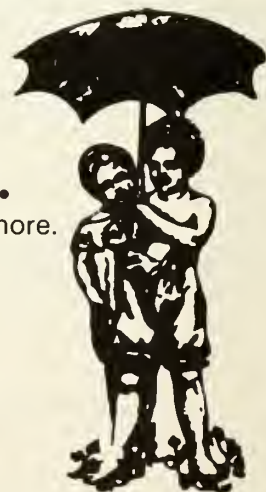
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Screening of Asymptomatic Women for Endometrial Carcinoma and Its Precursors*

VIJAYA V. GOWDA, M.D.,
JOSEPH APUZZIO, M.D., Newark

The increasing incidence of endometrial carcinoma seems to demand a more aggressive approach toward the diagnosis to reduce the mortality rates. If a patient becomes symptomatic, chance of a "cure" will not be as good as when a precursor lesion is discovered. Routine screening of premenopausal asymptomatic women at high risk for the development of endometrial carcinoma and all postmenopausal women should be performed.

The incidence of endometrial carcinoma, reported to be 11.9 cases per 100,000 female population, has been increasing in the United States in recent years.^{1,2} It is the fourth most common cancer in the female, preceded by cancer of the breast, colon, and cervix. With an increasing incidence there is a growing need for improved techniques for early diagnosis of endometrial cancer and its precursors. Only then by earlier diagnosis and treatment can the death rate of this disease be decreased.

RISK FACTORS

The significant high-risk factors for endometrial carcinoma are listed in Table 1. Recent reports have shown a four to eight-fold increase in the risk of developing endometrial carcinoma among women who are exposed to exogenous estrogen.³ Also, some patients with Turner's syndrome, who are receiving prolonged estrogen replacement without added progesterone, were found to develop endometrial carcinoma in the third to fourth decade of life.⁴ This is an early age for the disease to occur, as endometrial carcinoma is predominately a disease of the fifth and sixth decades of life. Gusberg⁴ has shown that adenomatous hyperplasia may be induced with continuous estrogen therapy in humans and lower animals and, if this stimulation is continued for a prolonged period of time without progestational modification of the endometrium, neoplasms may develop.

At menopause, the production of estrogens is decreased.

Yet there is a significant level of estrogen circulating predominately in the form of estrone. High levels of estrone may predispose to endometrial carcinoma. Estradiol is the predominant estrogen of premenopausal women. MacDonald and Sitteri have shown that estrogen production in the postmenopausal woman is obtained predominantly from the peripheral conversion in adipose tissue of androstenedione to estrone.⁴ From Sitteri's work there seems to be a correlation between obesity and the conversion rate: the greater the obesity the greater the conversion rate. This suggests that obesity is one of the risk factors in the development of endometrial carcinoma. Therefore, in postmenopausal women, there is a significant amount of estrogen (estrone) circulating without progestational modification of the endometrium. MacDonald and Sitteri have shown that obese, postmenopausal vaginal bleeders, and patients with endometrial carcinoma convert androstenedione to estrone at double the rate of age-matched controls.⁴

SCREENING TECHNIQUES

Women who have high-risk factors for the development of endometrial carcinoma should be evaluated. Although

*From Martland Hospital, New Jersey Medical School, CMDNJ, Newark, where Dr. Gowda is assistant professor in Obstetrics and Gynecology and Dr. Apuzzio is an instructor in the same department. Correspondence should be addressed to Dr. Apuzzio, Department of Obstetrics and Gynecology, Martland Hospital Unit, CMDNJ, 65 Bergen Street, Newark 07107.

Table I
High-Risk Factors for the Development of Endometrial Carcinoma

1. Obesity
2. Infertility or sterility
3. Co-existence of a functional ovarian tumor,
e.g., granulosa cell tumor
4. Persistent anovulation,
e.g., Stein-Leventhal Syndrome
5. Dysfunctional bleeding at the menopause
6. Postmenopausal women with hypertension and
diabetes
7. Postmenopausal estrogen therapy

Table II
Criteria for Mass Screening Devices

1. Simplicity of operation
2. Inexpensive and reliable
3. Safe and produce a minimum of discomfort
to the patient
4. Usable for ambulatory patients
5. Provide an adequate amount of tissue.

attempts have been made to diagnose endometrial carcinoma as an outpatient procedure for over a half a century, still the prime diagnostic test for this malignancy is fractional dilatation and curettage (D & C). Since many early neoplasms, and especially their precursors, are asymptomatic it is not practical or economically feasible to curette all women who are in the high-risk group. Therefore, other techniques will have to be considered in the mass screening of women in this category. During the past fifty years, investigators have developed and utilized numerous techniques to sample the endometrium. Most of the devices meet criteria listed in Table 2.

The sampling of the endometrium can be performed as an outpatient procedure by one of the following techniques:

1. Cytologic evaluation of secretions and/or aspiration
2. Endometrial biopsy
3. Suction curettage

Cytologic techniques include the brush technique, intra-uterine lavage, washers, and simple aspiration from the endometrial cavity. With the exception of the jet wash, these techniques yield an inadequate sample for evaluation and they have a high false-negative rate in the detection of endometrial lesions. A patent cervical canal is necessary for endometrial cells to reach the cervix and posterior vaginal fornix. In postmenopausal patients with endocervical stenosis malignant cells may not appear in the vaginal pool. The routine pap smear, which is accurate in the diagnosis of cervical lesions, is highly inaccurate in the detection of endometrial lesions. Recent reports have revealed that only one-third to one-half of all known endometrial carcinomas are detected with a pap smear.⁶ The main reason for such poor detection is that the cells are not removed directly from the lesion. So, at present, it is best to perform direct sampling of the endometrium.

The endometrial jet washer (Figure 1) is efficient in the early detection of endometrial carcinoma and its precursors particularly in asymptomatic patients. It has the advantage of a negative pressure sampling and does not disseminate neoplastic cells into the fallopian tubes. It enables the physician to wash out and at the same time to collect endometrial cells and tissue fragment samples. The accuracy rate is about 88 percent.⁷ Although it is considered a highly accurate technique, there still are some reservations with this procedure: (1) about 20 percent of the washings are inadequate for diagnosis, (2) in 10 to 15 percent of postmenopausal patients one is unable to enter the uterus because of endocervical stenosis, and (3) there is an increased time and effort required to process the material prior to evaluation.

Many authors have advocated the routine use of an office endometrial biopsy as a technique for diagnosing these

lesions. The important point to be made is that because the biopsy samples only a small portion of the endometrium, it can be considered satisfactory only if one finds an area of carcinoma. Recently, Hofmeister reported his extensive experience with endometrial biopsy in over 25,000 cases and claimed an accuracy rate of 94 percent⁹. Unfortunately all the patients with a negative biopsy did not have a dilatation and curettage procedure, so the true incidence of silent carcinoma of the endometrium is not known. The overall accuracy rate with endometrial biopsy is about 90 percent. Even with a negative biopsy, if sufficient risks exist, the patient should have a thorough curettage.

In 1968, Jensen and Jensen¹⁰ introduced a concept of vacuum uterine curettage (Figure 2) for the early diagnosis of endometrial carcinoma and its precursors. Since then this technique has received a favorable comment. Since the outside diameter of the cannula is about three mm, this procedure can be performed without causing much discomfort in peri- and postmenopausal women. The other advantage of this method is the attraction of putting the tissue through the normal histologic process prior to evaluation. Cohen and Gusberg¹¹ have performed simultaneous sharp curettage and vacuum curettage on a group of 100 patients. The accuracy rate in their extensive series is 92 percent. The main reasons for inaccuracy are the presence of an endometrial polyp or endocervical stenosis.

If an adequate endometrial sample is obtained from any of the above techniques and the lesion is benign, the patient then can be observed. If one discovers adenomatous hyperplasia or atypical endometrium, dilatation and curettage should be performed to rule out invasive carcinoma of the endometrium. If one is unable to obtain an adequate sample or, if the patient becomes symptomatic after obtaining an adequate sample, a diagnostic dilatation and curettage is mandatory.

CONCLUSION

Endometrial sampling, using one of the techniques previously described, should be performed on any premenopausal patient who is at high risk for the development of endometrial carcinoma (e.g., obese women) and on all postmenopausal patients. If one accepts the possibility that long-term estrogen therapy increases the risk of developing endometrial carcinoma, endometrial screening should be performed in these patients prior to initiation of estrogen therapy and repeated yearly. If a woman experiences any abnormal vaginal bleeding, even after endometrial sampling, a thorough fractional dilatation and curettage should be performed.

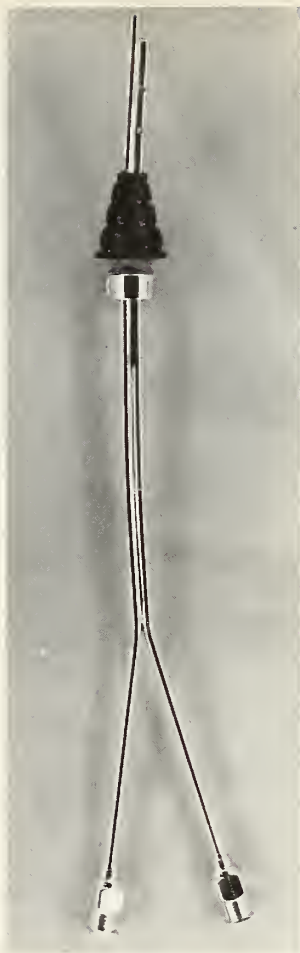


Figure 1 — Endometrial jet washer

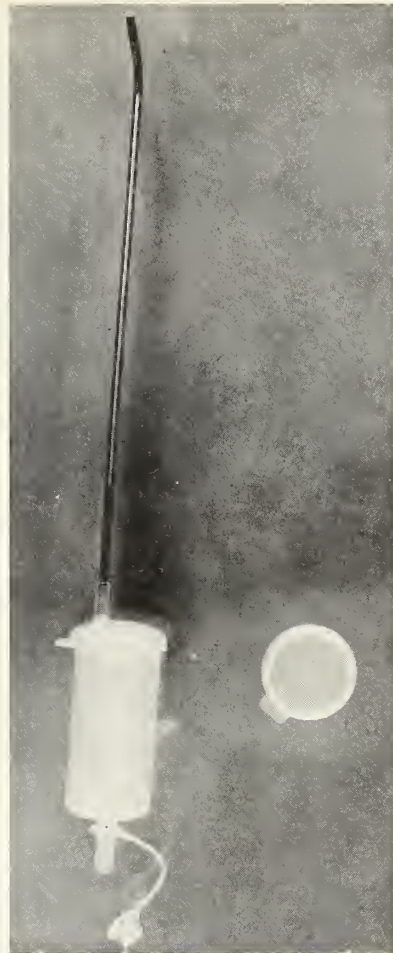


Figure 2 — Vacuum uterine curettage

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Interdigital Sinuses Of Barbers' Hands

JOSEPH R. DONAHUE,
JOHN K. DONAHUE, JR.,
JOHN N. SURMAY, R.P.
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A survey of barbers was conducted in Elizabeth to ascertain the incidence of interdigital hair sinuses, a malady not uncommon among them which rarely comes to the attention of a physician. A review of the literature on this subject calls attention to a close etiological relationship between interdigital sinuses and pilonidal sinuses.

Interdigital pilonidal sinus is an occupational condition among barbers which is caused by extraneous short hairs penetrating the skin and acting as foreign bodies. The sinus develops most often in the web space of the hand between the fingers. Waisman and Olivetti¹ have made the point that to many of the victims such a relatively trivial and non-disabling occupational event hardly merits seeking medical advice. On the other hand, occasionally a barber presents with an infection within the sinus which limits his ability to work.

CASE REPORT

A fifty-three-year-old male barber presented to the office in July, 1975 complaining of discomfort between his third and fourth fingers, left hand. He had been working at his occupation for 40 years and had not had a problem with his hands until several months previously. For a good part of his barbering life he was bothered by extraneous hairs sticking into his abdominal skin, however. These would be extracted with forceps by his wife periodically. The problem subsided when he began to wear a barber's frock 15 years ago. He also had had extraneous hairs embedding themselves into his feet.

Examination showed a foreign body reaction and sinus tract in the web space and after appropriate local therapy for several days the area was excised. Shortly after the wound had healed completely, a non-inflamed sinus tract containing three or four projecting hairs was detected in the same

area. The hairs measured 3 to 4 mm. in length. One month later he returned with an acute inflammatory reaction in the same web space, as well as a similar infection in the web space between the second and third digits of the opposite hand (right). Each responded to systemic antibiotics and local treatment.

A period of six weeks was allowed to elapse before the sinus (figure 1) on the right hand was excised. The wound healed well. Again, four months later a reaction occurred at the site of the original small sinus tract on the left hand. For each recurrence, the patient missed several days and on one occasion over a week of work. Finally he was given a pair of surgical gloves, instructed to cut the fingers from them and wear them to protect the web space. Thereafter, he became asymptomatic and discarded the gloves. The sinus tract of the left hand persists (figure 2). Some two years later he continues to have hairs stick into the skin of his web spaces but other true sinuses are not visible. The problem is worse in the summer time.

*Joseph Donahue presented this survey as an "independent study project" in fulfillment of requirements for graduation from the Pingry School, Elizabeth. He and his brother, John Donahue, Jr., a sophomore at Tulane University, New Orleans, conducted the survey and together were present at each interview. John N. Surmay is Director of the Office of Health, Welfare, and Housing, Elizabeth. Doctor Haims is a practicing surgeon in Elizabeth. He guided the project and treated the patient described. Correspondence may be addressed to Dr. Haims at 9 Stoneleigh Park, Westfield 07090.

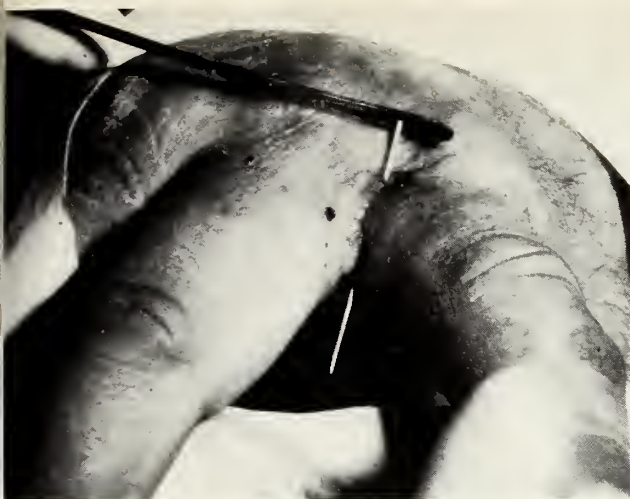


Figure 1—A chronically inflamed inter-digital sinus. A probe is inserted for clearer demonstration.

HISTORY

In 1880 Hodges² wrote: "Hair-cutters are continually in trouble from the short hairs which penetrate the skin of their fingers and hands." Interest in this condition seemed to lie dormant, however, until 1946 when Patey and Scarff³ described an interdigital sinus in a barber. In 1953 Currie *et al.*⁴ examined 77 gentlemen's hairdressers (barbers) in Glasgow and found ten among these who showed the condition. They also inspected the hands of sixty-one ladies' hairdressers and did not find one similar lesion. The following year Joseph and Gifford⁵ examined 115 barbers in the San Francisco area and fifteen were found to have interdigital hair sinuses.

MATERIALS, METHODS, AND RESULTS

The Department of Health, Welfare, and Housing, Elizabeth, New Jersey was contacted and a list of 62 Elizabeth barbershops registered with the State of New Jersey was obtained. Six had closed and therefore were not included in the study. A total of 59 barbers (all men) were visited, interviewed and examined in these shops while they were working.

Five barbers were found to have interdigital sinuses at the time of the survey, but only one had had difficulty with it. Two were not aware of the sinus' presence. Twelve barbers, at one time in their career, had been afflicted, but were able to obviate the sinuses by rubbing out the hairs with their fingertips and by washing their hands after each haircut. A total of 18 of the 59 were familiar with the condition. Many stated that hairs were often found imbedded in the skin of the interdigital webs and also under the edge of their finger-nail or cuticle.

Tait⁶ has pointed out that when a barber runs his hands through a customer's hair the clipped hairs gather in the webs. Presumably the barber would hold the scissors and cut hair with his dominant hand and use his other hand to hold hair, often between the fingers. It could be projected then that the non-dominant would be afflicted more with sinuses than the dominant hand. Our survey did not substantiate this concept. All 59 barbers studied were right-handed. Two had sinuses on the right hand, two had them on the left while one barber had them on both hands.

PATHOGENESIS OF THE LESION

Small cut hairs tend to collect in the web spaces of the



Figure 2—Recurrent sinus tract showing no inflammation. A solitary hair projects from it.

fingers of barbers during the course of their days' work. Hairs will accumulate more in the clefts particularly if they are moist. When clipped off obliquely to form a bevel, hair stubbles are needle sharp and not infrequently penetrate the epidermis and project from the skin surface. As a result of a secondary infection in the superficial corium, small pits are formed and more hairs gather in them with a consequent persistence and aggravation of these reactive changes. Small sinuses are produced. With continuation of the process deeper sinuses are subsequently formed. Once the hairs are imbedded, a chronic foreign body reaction may develop. Coarse hairs are more troublesome than others.⁴ An abscess may form at the tip of the sinus, point to the palm or web space and either rupture or be incised to form a fistula.

Hair follicles do not exist in the interdigital webs. This fact, together with the variety of the texture, thickness and color of the hairs found in the sinuses at any one given time, tends to support the concept that the hairs originate from an extraneous source.

DISCUSSION

Barbers are well acquainted with the traumatic and infective properties of short clipped hairs from male heads. A small inflammatory lesion of the skin may be produced around the hairs when embedded, but once they are removed the infection subsides. The hairs may stick into the skin of many parts of the body, including the nailbeds, the trunk, beneath the nails, the legs and feet, as well as the finger webs.

Although different in many ways, the condition "chronic scarring pseudofolliculitis" of the negro beard described by Pinkus⁷ illustrates the penetrating ability and sharpness of short clipped hairs. The lesion is caused by shaved hairs curling back and penetrating the epidermis. Matheson⁸ reported an interdigital sinus in a sheep shearer where the traumatic agent was a wool fiber. Stone⁹ has called attention to the fact that a paronychia in a male is almost always occupational. In one such case, he found a hair in a baker's chronic paronychia. The baker also doubled as a barber. It appears however, that the only frequent site of formation of a chronic lesion in barbers is the skin of the finger webs.

One of the strongest arguments for the postanal pilonidal sinus being an acquired condition is the occurrence of the analogous hair containing sinus seen in barbers' hands.^{10,11} Indeed, Goodall,¹² in reporting a series of pilonidal sinuses,

included, in addition to the common postanal condition, cases of hair sinuses in uncommon sites: axilla, front of chest, umbilicus, and barbers' hands.

TREATMENT

Goodall¹² also has shown that postanal sinuses may heal without surgical intervention. Joseph and Gifford⁵ have surmised that many barbers' sinuses heal spontaneously once the hairs are removed, also. The course of barbers' sinuses may be one of recurrence, repeated infection, and chronicity despite therapy. Joseph and Gifford⁵ report a particular barber who had recurring sinuses and scars where the sinuses were removed. In those cases where chronicity ensues, excision of the sinus tract with primary closure seems to be the treatment of choice. Occasionally, a skin graft has been required.

CONCLUSION

1. Barbers' interdigital sinus is not an uncommon condition, but it seldom reaches medical attention because of its benign nature.
2. The condition occurs in those craftsmen who cut men's hair and is familiar to many of them.
3. Five of fifty-nine Elizabeth, New Jersey, barbers were found to have the lesion.
4. Many believe the importance of barbers' interdigital sinus lies in its analogous relationship to postanal pilonidal disease.

5. Careful hygiene, cleanliness, and the manner and frequency of washing hands seems to play a part in limiting the disease.⁴

6. The literature and clinical examination of many barbers clearly substantiates that interdigital hairs originate from extraneous sources.

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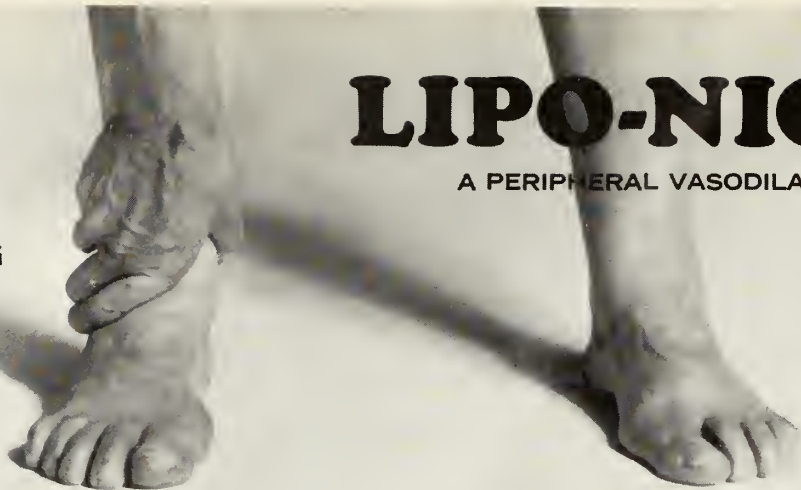
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Indications: For use as a vasodilator in the symptoms of cold feet, leg cramps, dizziness, memory loss or tinnitus when associated with impaired peripheral circulation. Also provides concomitant administration of the listed vitamins. The warm tingling flush which may follow each dose of LIPO-NICIN 100 mg. or 250 mg. is one of the therapeutic effects that often produce psychological benefits to the patient. Side Effects: Transient flushing and feeling of warmth seldom require discontinuation of the drug. Transient headache, itching and tingling, skin rash, allergies and gastric disturbance may occur. Contraindications: Patients with known idiosyncrasy to nicotinic acid or other components of the drug. Use with caution in pregnant patients and patients with glaucoma, severe diabetes, impaired liver function, peptic ulcers, and arterial bleeding.

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Organization and Function of the Firms System in an Urban-Located College Hospital

CARROLL M. LEEVY, M.D. and
DENNIS QUINLAN, M.D., Newark

CMDNJ has adopted a modified Firms System for its teaching services at Martland Medical Center and the successor college hospital. The Firms System facilitates student and house officer education, inpatient and outpatient health care delivery, and the pursuit of clinical investigation or research in health care delivery. When fully implemented, this System will be the ideal format for an urban college hospital which must accept responsibility for both high-caliber primary and tertiary care. As utilized it has allowed the faculty and housestaff to employ the newest approaches to recognition and treatment of diseases, while establishing and maintaining the climate required to produce sensitive, knowledgeable, and inquisitive physicians.

The need for more primary care physicians has led to the establishment of family practice departments, and a restructuring of the specialty of internal medicine.¹ Efforts are under way to provide students with requisite theoretic knowledge and practical experience to fulfill this need. This led the Department of Medicine of the New Jersey Medical School, College of Medicine and Dentistry of New Jersey, to adopt the Firms System for its teaching program at Martland Medical Center in March of 1975. This System, which has been employed widely by teaching hospitals in England and commonwealth nations, has had a major impact on education, patient care, and research on the Newark campus.

ORGANIZATION

The Firms System consists of a group of faculty, interns, registrars, medical students and sisters (nurses) organized to provide high-caliber medical education and health care. It is based on the availability of a first-rate clinical medical faculty and nursing staff who work closely with social workers, dietitians, physiologic technicians, psychologists, and other paramedical personnel to ensure optimum instruction of medical, dental, nursing, and allied health students (Figure 1). Ancillary personnel are incorporated in the patient care-student-faculty group and are encouraged to assume a complementary role with full membership in a given Firm. Attention to primary care and general internal medicine,

while maintaining a divisional structure for tertiary care (Figure 2) in the Firms System, conforms to the graded residency program first instituted at Johns Hopkins Hospital.² This approach has permitted the faculty to fulfill its agreed-to responsibilities to the local community in which the college is located,³ and to establish the one-to-one physician-patient relationship required for proper health care delivery.

The Martland Medical Service is divided into three geographically discrete inpatient-outpatient Firms, each of which is responsible for patient care, education, and clinical research. Firm teams provide patient care in Intensive Care, Renal Dialysis, and Physiologic Study Units. The Firms now are headed administratively by senior faculty who serve as Firm Chiefs, intermediate faculty who serve as Associate Firm Chiefs, and junior faculty who serve as Assistant Firm Chiefs. The Assistant Firm Chiefs perform special tasks, such as coordination of outpatient activities and provision of special educational services. Each Firm is divided into four teams headed by a faculty attending, ninety percent of whom

*From the Department of Medicine, New Jersey Medical School, CMDNJ. Presented at the New Jersey Regional Meeting, American College of Physicians, November 9, 1977. Dr. Leevy is Professor and Acting Chairman, Department of Medicine, New Jersey Medical School, and Dr. Quinlan is Assistant Professor and Director, Division of General Medicine, Department of Medicine, New Jersey Medical School, Newark. Correspondence may be addressed to Dr. Leevy at the College, 100 Bergen Street, Newark 07103.

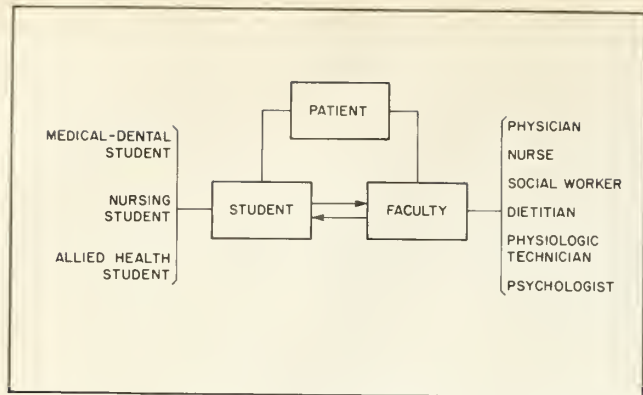


Figure 1—Organization of the educational unit in internal medicine in a teaching hospital.

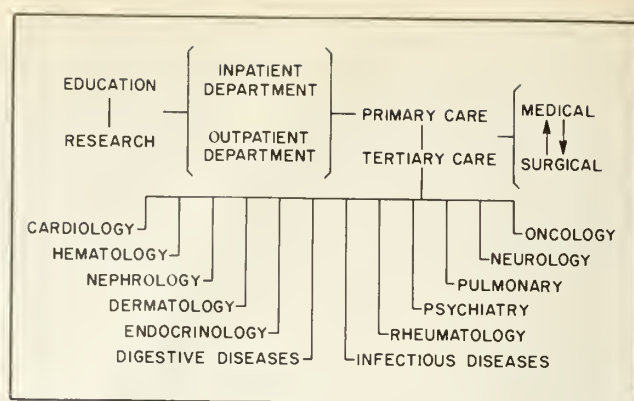


Figure 2—Conventional relationship of primary and tertiary care, using divisional structure.

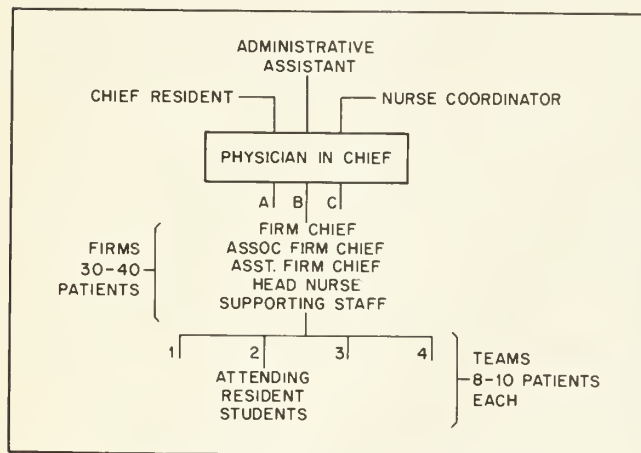


Figure 3—Format of Firms System at New Jersey Medical School.

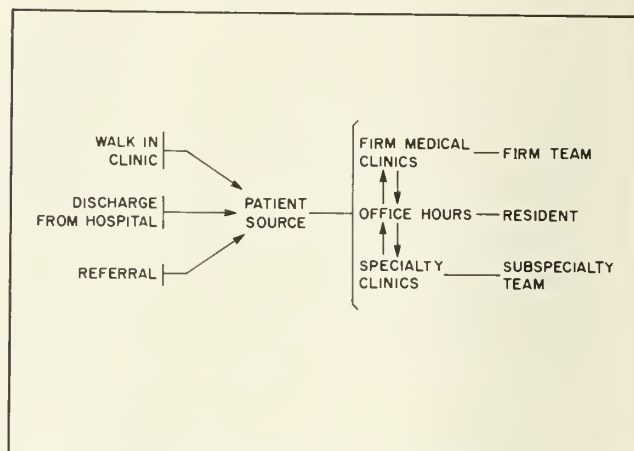


Figure 4—Outpatient organization in Firms System at New Jersey Medical School.

are subspecialists, and ten percent internists without subspecialty training. Faculty attendings serve for blocks of time as primary care physicians and as consulting subspecialists, maintaining a panel of primary and tertiary care patients. Each team includes junior and senior residents in internal medicine, and one or more junior and/or senior undergraduate students. Overall cohesiveness is achieved through the physician-in-chief, the chief resident physician, and the nurse coordinator (Figure 3). Separate monthly administrative meetings are held with assigned faculty, housestaff, students, nurses, and supporting staff.

EDUCATION

Experience in patient care is provided for students and house officers under the direct supervision of full-time and voluntary faculty in the inpatient and outpatient departments. Grading of clinical performance by undergraduate students is supervised by the Associate and Assistant Firm Chiefs. Clinical competence of residents is assessed by the Firm Chief and attendings. This arrangement has facilitated ability to quantify skills, motivation, and performance by students and house officers; objective evaluation with stipulated requirements has improved academic performance.

The standard format of a university teaching service has been continued within the context of the Firms System, including morning report sessions for students and house-officers; inpatient team rounds; and morning, afternoon and early evening ambulatory clinics. A Death and Discharge Conference and Firm Rounds, which include all teams, sub-

specialty consultants, and supporting staff, are held each week. Major didactic educational conferences consist of (a) subspecialty teaching conferences; and (b) basic clinical science seminars. In the latter conferences, a patient is presented who illustrates one or two salient new facts in a specific area. Discussions tailored to focus on a given problem then are conducted by members of the basic science and clinical faculty.

PATIENT CARE

Performance in the inpatient service is monitored daily by the Associate Firm Chief, and weekly by the Firm Chief. Administrative aspects of ambulatory care are monitored by an Assistant Firm Chief; social workers, dietary staffs, and physiological technicians provide services for both inpatient and outpatient areas. Of 2,544 patients admitted to the Medical Service of Martland Medical Center during 1976-77, 80 percent were hospitalized for primary care, and 20 percent for tertiary care. Patients who receive primary care are admitted after an initial evaluation in the outpatient department or emergency service, and are cared for in a critical care unit, regular medical ward, or an extended care unit (Figure 4). Subspecialists representing each discipline of internal medicine are attached to Firms where they serve, on a continuing basis, as consultants and carry out special procedures. Subspecialists are in charge of specialty units, for coronary care, intensive care, and renal dialysis. Combined input by generalists and specialists is thus provided for patients in need of primary care as well as those who are

hospitalized for tertiary care.

Faculty-house officer-student teams representing each Firm are allocated specific times in medical clinics where 29,804 patients were seen in 1976-77. In addition, "office hours" are provided for faculty, residents, and students to maintain long-term follow-up of patients (Figure 5). Specialty clinics serve primarily for consultation, periodic follow-up of problem cases, and clinical studies.

CLINICAL INVESTIGATION

The Firms System is used as a device to encourage controlled studies required to evaluate the merits of established or new diagnostic and therapeutic procedures. Students, residents in internal medicine, subspecialty residents, research fellows, and faculty participate in a variety of investigative programs in the Department of Medicine of the New Jersey Medical School, utilizing predesigned formats for diagnosis and treatment of selected medical disorders. Faculty-house staff-student teams function as separate entities, thus permitting comparison of results of accepted modalities. Random admissions and uniformity of approaches permit collection of data from which valid impressions and conclusions can be made. In addition, the Firms System provides the matrix for research and medical education. Planned programs include evaluation of having a psychiatrist serve as an integral part of Firms, and use of community counsellors to facilitate patient care and compliance in hypertension, diabetes, alcoholism and sickle cell diseases. A reduction in patient morbidity and mortality experienced under the Firms System, as in other university medical services, is attributable, in part, to properly controlled and monitored research.

NEW COLLEGE HOSPITAL

There are four physically discrete Firms, each consisting of 30 percent care beds, in single or double occupancy rooms, in the new College Hospital, construction of which will be completed in the spring of 1978. The Firms faculty-house officer-student teams will continue to cover emergency care units, physiologic subspecialty units, and primary and tertiary care clinics. This will be more feasible since faculty offices and research laboratories in the Medical Science

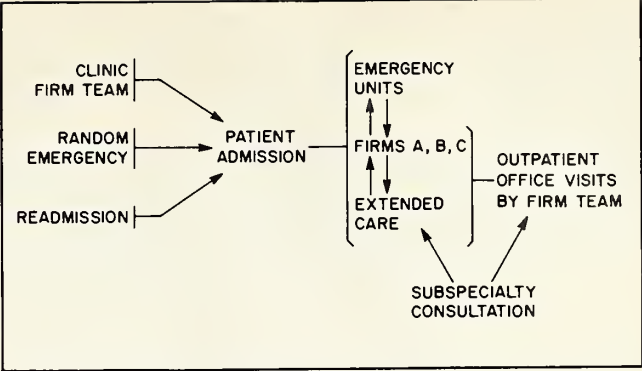


Figure 5—Inpatient organization in Firms System at New Jersey Medical School.

Building, which houses both clinical and basic science departments of the New Jersey Medical School and the Graduate School of Biomedical Sciences, are adjacent to the inpatient service area.

Admission of private patients by voluntary faculty who participate in the Firms will be extended, thus ensuring a varied educational exposure for undergraduate medical students and house officers, and a broader opportunity for private practitioners and patients. The one-to-one patient-physician relationship will allow ready adaptation to a National Health Insurance program, or its equivalent, designed to provide professional fee capability for all patients. Continuing attention to medical education and applied or basic research will provide the academic climate required for high-caliber health care for the local community and state.

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Hypertension Recurrence in Patients Receiving Anti-Hypertensive Therapy

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The charts of 200 patients attending the East Orange Veterans Administration Hospital Hypertension Clinic were examined. Over 60 percent had recurrence of hypertension after initially achieving control. The majority of these patients became normotensive again without an increase in their medications. This suggests that intermittent control is part of the natural progression between persistent hypertension and sustained normotension in patients receiving anti-hypertensive agents. It appears unnecessary to alter the therapeutic regimen each time an elevated blood pressure is noted in a patient previously controlled with anti-hypertensive drug therapy.

Current literature leaves little doubt as to the desirability of blood pressure reduction in hypertensive patients. However, despite the use of drugs which can normalize the blood pressure in 85 percent of patients, current surveys suggest that only 50 percent of hypertensive patients are controlled.^{1,2} This discrepancy has been attributed to both patient and physician "failure" and a number of studies and remedies have been suggested.^{3,4} All assume that the presence of an elevated blood pressure recording in a patient undergoing anti-hypertensive therapy is indicative of ineffective therapy. The current study suggests that this assumption is not correct.

METHODS AND POPULATION

Clinic—The East Orange Veterans Administration Hospital Hypertension Clinic offered free medical care and medication to over 1000 veterans between December 1974 and January 1977. All patients accepted at the clinic had a diastolic (fifth point) blood pressure in excess of 90 mmHg or a mean arterial pressure ($\text{MAP} = \text{diastolic} + \frac{\text{pulse pressure}}{3}$) greater than 107 mmHg on three or more visits at least one week apart. Patients who were normotensive while receiving anti-hypertensive medications also were admitted to the clinic.

The majority of patients were treated with diuretics first. Additional medications included alpha-methyl dopa, reserpine, clonidine, guanethidine, propranolol, and hydralazine.

Although these generally were added in a step-wise fashion, patients with markedly elevated pressures frequently were begun on more than one medication. Reminders were sent to patients who missed their appointments.

Procedures—The files of 200 male patients were selected randomly. Each patient's course was divided into quarterly intervals and his MAP noted on that visit which most closely corresponded to his initial, one-quarter ($3.0 \pm 2.2^\dagger$ months), one-half (6.6 ± 3.4 months), three-quarters (10.1 ± 4.4 months), and final (14.1 ± 5.1 months) visit. A MAP of ≤ 107 mmHg was considered normal.

Population—Of the 200 patients evaluated, 93 were white, 106 were black, and one was Chinese-American. Their mean age was 56.3 ± 10.0 years. Patients were seen 8.3 ± 3.2 times with a mean interval between visits of 1.7 ± 0.6 months. On the initial visit to the clinic, 141 patients were receiving anti-hypertensive medications of whom 54 were normotensive. The mean initial MAP of all patients was 118.2 ± 15.3 mmHg. The distribution of MAP among the patients is shown in Table 1.

*From the Hypertension Section, Department of Medical Service, Veterans Administration Hospital, East Orange, and New Jersey Medical School, CMDNJ Newark. Presented at the New Jersey Regional Meeting, American College of Physicians, November 9, 1977. Requests for reprints should be addressed to Dr. Modlinger at the Veterans Administration Hospital, East Orange 07019.

[†]Index of dispersion is ± 1 Standard Deviation for all data.

Table 1
Distribution of Mean Arterial Pressure Among
Patients at Initial and Final Visits

MAP (mmHg)	Number of Patients	
	Initial Visit	Final Visit
≤ 107	54	128
108-110	16	15
111-115	20	18
116-125	52	30
126-135	35	5
> 135	23	4

Table 2
Changes in MAP During Therapy

Visit	Normotensive at Presentation ^a	Hypertensive at Presentation ^b
Initial	100.0 ± 5.6	124.8 ± 16.9
One-Quarter	104.3 ± 10.3	116.6 ± 14.8
One-Half	106.9 ± 12.5	115.3 ± 15.8
Three-Quarters	104.1 ± 9.7	112.0 ± 9.7
Final	101.2 ± 8.3	106.4 ± 12.8
Change in MAP (initial-final)	±1.2 ± 9.6	-18.2 ± 16.3

^a 54 patients receiving anti-hypertensive medication at presentation.

^b 146 patients: including 87 patients receiving anti-hypertensive medication at presentation and 59 patients untreated at presentation.

COURSE OF THIRTY-SEVEN PATIENTS BECOMING
NORMOTENSIVE ON THEIR ONE-QUARTER VISIT

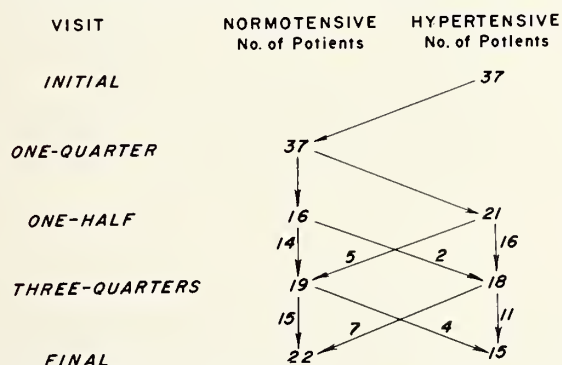


Figure 1

COURSE OF FORTY-THREE PATIENTS BECOMING
NORMOTENSIVE AT THEIR ONE-HALF VISIT

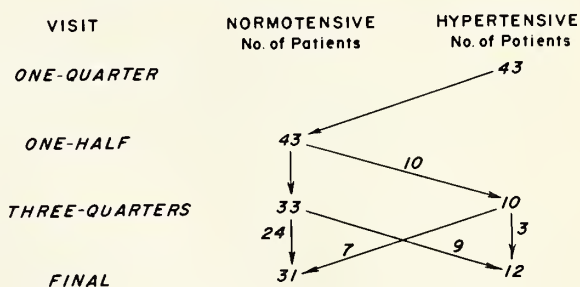


Figure 2

COURSE OF THIRTY-NINE PATIENTS BECOMING
NORMAL AT THEIR THREE-QUARTER VISIT

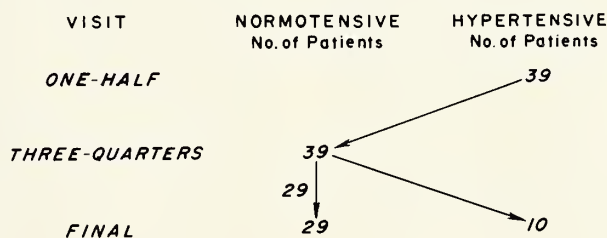


Figure 3

RESULTS

Final Outcome—The final MAP of all patients was 105.1 ± 12.0 mmHg with a mean fall in MAP of 13.1 ± 17.0 mmHg. Table 1 indicates the distribution of MAP at the final visit. Table 2 indicates the changes in blood pressure among those patients originally normotensive on medications as well as those initially uncontrolled on and off medications.

Fluctuating Control—Figures 1 to 3 illustrate the frequency of hypertension recurrence and subsequent blood pressure variability observed in patients becoming normo-

tensive at their one-quarter, one-half, and three-quarters visit. Over 60 percent of patients were hypertensive at least once following achievement of control. Table 3 indicates that reduction in medication dose had taken place in fewer than 10.6 to 35.0 percent of these patients. Fewer than 30.0 to 59.5 percent of patients achieving control had had an increase in medication during the preceding quarter-interval (Table 4).

Missed Appointments—Patients normotensive at the final visit missed 1.4 ± 1.2 appointments, while patients who were hypertensive at the final visit missed 1.5 ± 1.3 visits (p = NS). Missed appointments during the first half of the treat-

Table 3
Patients Becoming Hypertensive After Being Normotensive

Interval	Normotensive at Interval Start (n)	Becoming Hypertensive During Interval			
		Total (n)	% ^c	Without Cut in Medication (n)	% ^d
Initial	54	20	37.0	13	65.0
1/4 - 1/2	71	35	49.3	25	71.4
1/4 - 3/4	79	21	26.6	15	71.4
3/4 - Final	97	19	19.6	17	89.4

^c Expressed as total number of patients becoming hypertensive ÷ number of normotensive patients at interval start.

^d Expressed as number of patients becoming hypertensive without medication cut ÷ total number becoming hypertensive.

Table 4
Patients Becoming Normotensive

Interval	Hypertensive at Interval Start (n)	Becoming Normotensive During Interval			
		Total (n)	% ^e	Without Medication Increase (n)	% ^f
Initial - 1/4	146	37	25.3	15	40.5
1/4 - 1/2	129	43	33.3	20	46.5
1/2 - 3/4	121	39	32.2	24	61.5
3/4 - Final	103	50	48.5	35	70.0

^e Expressed as total number of patients becoming normotensive ÷ number of hypertensive patients at interval start.

^f Expressed as number of patients becoming normotensive without a prior increase in medication ÷ total number becoming normotensive.

ment period (0.64 ± 0.78 visits) did not differ significantly from missed appointments during the second half (0.55 ± 0.68 visits).

DISCUSSION

It commonly is believed that therapy with anti-hypertensive agents results in a smooth and continuous fall in blood pressure among responding patients and that normal blood pressure, once achieved, is sustained for long periods of time barring poor compliance, worsening disease, and/or secondary drug failure.⁵ This misconception is evident in the practice of defining treatment success as the number of normotensive patients at a given time and assessing treatment failure by the number of hypertensive patients on a spot survey.^{4,6}

The attainment of normal blood pressure in 64 percent of our patients on the occasion of their most recent visit, following 14 months of therapy, is similar to results obtained in other urban settings.^{7,8} This figure significantly underestimates treatment success, however, since 86 percent of our patients were normotensive on at least one-quarter of their visits. The discrepancy between these two "success" figures is due to the reemergence of hypertension in over 60 percent of responding patients. That the return of hypertension was not always due to drug reduction is indicated in Table 3: Fewer than 25.7 ± 10.5 percent of patients exhibiting loss of control had had their drug dosage cut.

The reappearance of hypertension following initial control usually did not indicate worsening disease. Over 85 percent of these patients were found to be normotensive again on subsequent visits despite failure to increase medication dose in the majority (Table 4). This suggests that intermittent normotension may be part of the natural response to anti-hypertensive medications and form a link between persistent hypertension and sustained normotension. Such a

possibility is reinforced by the observed diminishing incidence of hypertension reemergence with time on therapy (40.3 percent of patients normotensive at their one-quarter visit, 26.6 percent of patients normotensive at their one-half visit, and 19.6 percent of patients normotensive at their three-quarters visit). Stamler, monitoring patients at one to two years after therapy (as opposed to our follow-up of 14 months) found that only 11 percent of her patients became hypertensive again after initially achieving control.⁹

Although it is possible that the diminished blood pressure fluctuation noted toward the close of our follow-up period reflected increasing compliance, this is unlikely since compliance generally diminishes with prolonged therapy.¹⁰ Clinic attendance during the latter half of therapy did not differ significantly from that during the first one-half.

Variability of blood pressure among hypertensive subjects has been described in screening surveys,¹¹ but largely is unrecognized among patients undergoing anti-hypertensive therapy. The widespread occurrence of reemergence of hypertension during therapy noted in the current investigation suggests that current medical practice be altered to take these fluctuations into account. A hypertensive reading, for example, has less significance in a patient previously controlled than in an individual never normotensive. A given elevation seems of particularly little significance in the first few weeks and months following initial control since this occurs in the majority of patients. It would appear unnecessary, therefore, to alter medication dosage each time the blood pressure is noted to increase as such practice unnecessarily increases drug cost, raises the incidence of drug side effects, and diminishes patient compliance. The practice of scheduling revisits based upon isolated blood pressures also ignores the past history of blood pressure control and leads to unnecessary clinic crowding and expense. Patients recently controlled perhaps should continue to return at infrequent

intervals despite the detection of an elevated pressure. The present study indicates that subsequent recordings will reveal return of normotension in the majority.

The current retrospective study does not allow distinction between the majority of "relapsing" patients with a good prognosis and those with a poor likelihood for return of normotension, in whom the reappearance of hypertension does indicate drug failure. A prospective study in which parameters of past history, social stress, and end organ damage are assessed for their predictive value in indicating the necessity of drug increment appears indicated. It is hoped that description of the frequency with which hypertension reemergence occurs as a benign phenomenon will serve as the impetus for such an investigation.

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Accidental Hypothermia— A Brief Review

FRANCIS P. CHINARD, M.D., Newark

The course of two patients with accidental hypothermia is presented. The manifestations and the role of predisposing disorders and underlying diseases are discussed with respect to management and prognosis. Patients with core temperatures higher than 30° C without serious complicating disease can be managed adequately with active or passive external rewarming. Active rewarming is mandatory for core temperatures below 30° C because of the probability of ventricular fibrillation. Defibrillation is unlikely to be successful below 30° C. Core rewarming by hemo- or peritoneal dialysis is effective but still experimental and probably is not indicated generally for core temperatures above 30° C.

Disorders of temperature regulation are manifested clinically in patients by departures of the body temperature from the normal range. Such abnormalities usually result from one of a limited number of possible causes (e.g., fever associated with infection or hypothermia due to exposure to cold). In some circumstances, a more specific problem may be singled out. I have attempted to indicate here some of the major current concepts involved in the evaluation and management of patients with hypothermia. Examples of some of the types of problems encountered are illustrated in the two summaries which follow.

PATIENT REPORT #1

Subjective data: A 33-year-old, unemployed man was found in the street lying asleep in the snow. He was brought to the Martland Hospital Emergency Room by the police. No history could be obtained at the time but he later remembered that he had been drinking at a bar, left the bar, and presumably then "passed out." The only significant aspects of his history were a ten-year period of drinking at least a pint of vodka per day and an episode of delirium tremens five years previously.

Objective data: The patient was found to be quite thin but normally developed and appeared to be his stated age. He was acutely ill and responsive but agitated, confused, disoriented, and hallucinating. Temperature was 87° F (30.6° C), pulse was 140/minute and irregular; respirations 24/minute;

BP 90/60 Torr. The skin was quite cold and there was a "frostbitten" area on the dorsum of the right hand. On auscultation, the heart rhythm was irregular but there were no murmurs. The remainder of the physical examination was within normal limits.

Laboratory data: Hgb was 13.3g/dl, Hct 41.2, and MCV 108 μ^3 . The peripheral blood smear showed macrocytosis; WBC was 12,900/mm³ and the differential showed 83% polymorphonuclear leucocytes, 16% lymphocytes, and 1% monocytes. Blood urea nitrogen was 30mg/dl, creatinine 1.3mg/dl, glucose 84mg/dl sodium 139, potassium 5.3, chloride 95, and total CO₂ 17mM/liter. Blood ethanol was 37Mg/dl. Folate concentration of 1.5m g/ml was reduced significantly. Thiamine concentration was within normal limits. ECG showed supraventricular tachycardia with frequent atrial premature contractions.

Assessment: 1) Hypothermia due to exposure, 2) metabolic acidosis, 3) alcohol withdrawal syndrome, 4) chronic alcoholism, 5) folate deficiency.

Hospital course: The patient was warmed slowly with a controlled blanket to 98° F over a period of six hours. He also received warmed 0.9g/dl sodium chloride solution and

*From the Department of Medical Service, Martland Hospital Center and Department of Medicine, New Jersey Medical School, CMDNJ, Newark, where Dr. Chinard is Professor of Research Medicine. Presented at the New Jersey Regional Meeting, American College of Physicians, November 9, 1977. Dr. Chinard may be addressed at the College, 100 Bergen Street, Newark 07103.

44mM of sodium bicarbonate intravenously. Temperature rose to 101° F on the day following admission. The patient was given ampicillin because of leucocytosis and neck stiffness (spinal tap could not be done) and his temperature and leucocytosis returned to normal limits as did the physical signs. However, full-blown delirium tremens developed by the fourth day. He responded to conventional management with fluids and sedation, and was discharged ten days after admission apparently having recovered from his acute problems. He was to be followed in the appropriate clinics for alcohol addiction and liver disease and by the social service department.

PATIENT REPORT #2

Subjective data: An unconscious 18-year-old male was found lying on a sidewalk without shoes or jacket at about 6 a.m. in mid-December (ambient temperature about 15° F or -9.4° C) and was brought to the emergency room of Martland Hospital by ambulance. Here, too, no history could be obtained; later the patient admitted having taken two grams of glutethimide and tablets containing a mixture of secobarbital and amobarbital. His past history was unremarkable except for occasional trials with heroin and alcohol and a previous admission to the Martland Hospital for a possible glutethimide overdose a year previously. He had worked as a retail clerk after graduation from high school but currently was unemployed.

Objective data: In the emergency room, the patient was unresponsive. His skin was cold; respirations were shallow; muscles were rigid; and temperature with a standard clinical thermometer was 88° F (31.1° C). He did not respond to intravenous naloxone and was transferred to the medical intensive care unit after intubation. He was noted to be well developed and well nourished and now responsive to painful stimuli. Temperature was 93° F (33.9° C) by rectal probe, pulse 100/minute and regular, respirations 15/minute (on respirator), and BP 130/86. He had superficial abrasions over his right eye, both cheeks, and hands and his upper lip was swollen. Pupils were dilated and reacted sluggishly to light. No extraocular movements could be elicited except by

cold caloric test (movement conjugated to stimulated side). Lungs were clear to percussion and auscultation. The cardiac sounds were regular and well heard; there were no murmurs. Muscle rigidity had disappeared; the remainder of the physical examination was within normal limits.

Laboratory data: Hgb was 15.6g/dl, Hct 45.4, MCV 87μ³; WBC were 8,400/mm³ and the differential showed 64% polymorphonuclear leucocytes and 36% lymphocytes. Platelets were adequate. Blood urea nitrogen was 11mg/dl, creatinine 0.7mg/dl, glucose 210mg/dl. Sodium was 138, potassium 4.0, chloride 108 and total CO₂ 26, and anion gap 8mM/liter. Arterial blood gases (on room air) were pH 7.30 PO₂ 107, PCO₂ 51mm/Hg, total CO₂ 27mM/liter. ECG showed bradycardia, normal axis, and typical J-waves (see Figure 3).

Assessment: 1) Hypothermia due to exposure, 2) drug abuse, 3) abrasions of face and hands.

Hospital course: The patient was rewarmed actively with a hypothermia blanket at a rate of 2° F or approximately 1° C per hour. He responded rapidly. Electrocardiographic abnormalities spontaneously reverted to normal as the temperature reached 94° F (34.4° C). Monitoring showed no complications. Fourteen hours after admission blood gases, electrolytes, urea, and glucose concentrations were all within normal limits. The patient was to be offered counseling and to be referred to a community agency for followup.

DISCUSSION

General considerations—Hypothermia, defined as a decrease of body temperature of such an extent that there results detectable abnormalities in bodily functions, can occur in a number of situations. That it occurs is always the result of an imbalance among heat input to the body, endogenous heat production and heat losses (Figure 1). The heat content of the body is determined not only by body mass (a heavy individual will have a greater heat content than a lighter one) but also by body composition (the heat capacity of fat is less than that of water). However, since lean body mass is about the same in fat and lean individuals of the same body height, fat individuals will have the edge on the lean ones with respect to heat content. Similarly, edematous patients (ascites, anasarca) will have a greater heat content than non-edematous individuals and if hypothermic they will require, other things being equal, a greater input of calories to rewarm a given number of degrees than non-edematous individuals.

Heat losses can be increased by radiant and connective processes (Figure 1). Thus, both our patients would have been expected to lose more by radiation from face, hands and other exposed portions of the body to walls and the sky. They also would have lost more by convection (conduction) by contact with the snow or cold ground. Finally, as body temperature dropped, the endogenous heat production also would have decreased from the slowing of metabolic processes. If the patients had not been picked up by police or ambulance crew, the outcome could have been lethal. Obviously, the degree of cooling is limited by the temperature of the environment in contact with the subject.

Predisposing disorders—As reviewed recently by Maclean and Emslie-Smith, the disorders predisposing to hypothermia can be divided into four groups.¹ The first group involves problems of decreased heat production and includes hypothyroidism, hypopituitarism, starvation, and malnutrition, conditions in which there is reduced muscle activity and absence of shivering (strokes, arthritis, Parkinsonism).

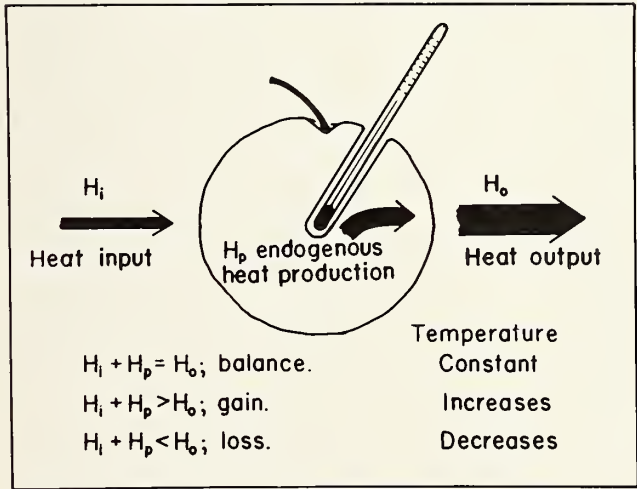


Figure 1—Heat balance and core temperature.
 $S = H_p \pm R \pm C - E$ where:
 S = rate of heat loss or gain
 H_p = rate of endogenous heat production. H_p is approximately:
50 Kcal x hour⁻¹ x M² or
1660 Kcal day⁻¹ x (1.73 M²)⁻¹
 R = rate of radiant heat exchange
 C = rate of convective heat exchange
 E = evaporative heat loss

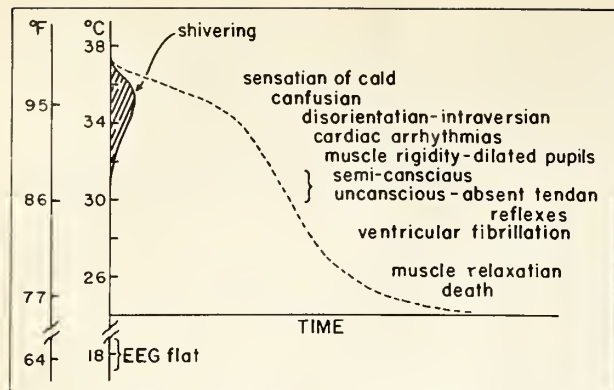


Figure 2—Clinical manifestations of hypothermia. (Modified from Golden.² Shivering may be suppressed and mental changes obscured in certain situations such as in acute alcoholic intoxication.

Hypothermia in and of itself will result in decreased heat production. The second group involves problems of increased heat loss and includes erythroderma (any increased perfusion of the skin), decreased subcutaneous fat, immersion, exposure to cold, and ethanol intoxication (our patient). The third group involves problems of thermoregulation and includes brain damage (due, for example, to trauma, hemorrhage, hypoxia), drugs (such as barbiturates, salicylates, acetaminophen, tricyclic antidepressants, organophosphates), and uremia and diabetic ketoacidosis. The fourth group is a miscellany which includes cardiovascular diseases, pancreatitis, bronchopneumonia, disseminated tuberculosis.

Manifestations—The extent of the hypothermia may not be appreciated fully if thermometers with adequate ranges are not available. If the thermometer does not register temperatures below 96°F (a problem in our emergency room), the attending physician may be misled as to the seriousness of the problem, the vigor with which the re-warming must be pursued and the prognosis. A calibrated thermistor or thermocouple probe is easier to use to measure "core" (rectal) temperature than is a 40cm long laboratory mercury thermometer. Some such devices should be available in every emergency room and in every medical intensive care unit. (Use of a thermistor probe in the esophagus is probably contraindicated because of the possibility of inducing ventricular fibrillation.)

The clinical manifestations of hypothermia are illustrated in Figure 2, a modification of the schema developed for immersion hypothermia by Golden.² The salient features are the mental symptoms (confusion, disorientation) in the early stages and the cardiac abnormalities which develop as the hypothermia deepens. For convenience, as suggested by Hervey³ we can consider three stages in hypothermia. The first, readily reversible and generally associated with shivering (but much less frequently in elderly patients) covers the temperature range down to 32°C (89.6°F). The second, transitional, stage where tissue metabolism is depressed, vasoconstriction still can be intense, and arrhythmias are likely, covers the range from 32°C down to about 30°C (86°F). The third or danger zone covers the temperatures below 30°C where heat conservation, as well as heat production, is depressed, loss to a colder environment can continue and ventricular fibrillation is to be expected.

The physiological and pathological manifestations are intertwined but can be summarized as follows. The metabolic rate, as indicated by oxygen consumption, falls more or less rapidly depending on the extent of shivering. Carbon dioxide

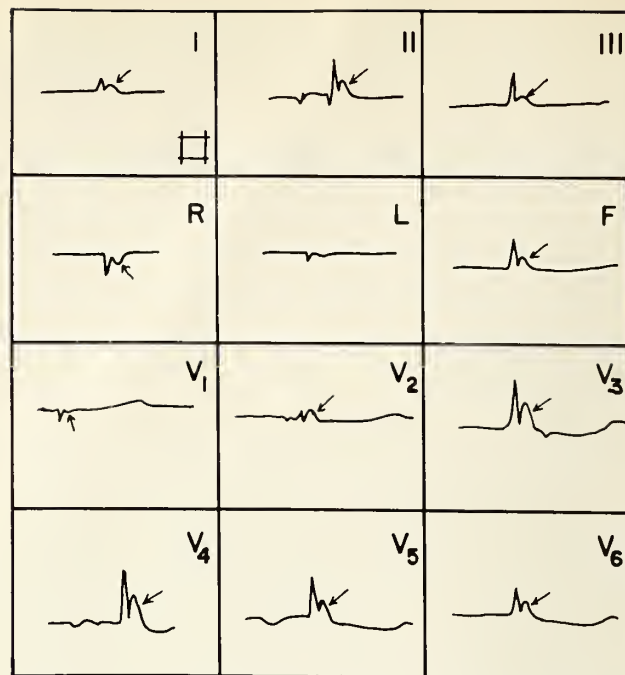


Figure 3—Electrocardiographic changes. These are tracings from patient 2 and show the initial "J" waves (arrows) when temperature was 88°F (31.1°C). The electrocardiogram reverted to a normal pattern as the patient's temperature approached normal.

production may increase relatively, again with shivering, but generally will be depressed more than the oxygen consumption so that the respiratory quotient approaches unity. Glucose utilization is decreased and there may be associated hyperglycemia. However, in patients who are alcoholics, glycogen stores may be depleted and there may be hypoglycemia. Along with these changes in carbohydrate metabolism there is usually an increase of free fatty acids and the possible myocardial effects of these may play a role in the eventual cardiac dysfunctions. The metabolic acidosis (noted in our first patient) probably results mainly from an increase of lactate which if not measured is reflected by an increased anion gap (approximately 30mM/L in patient one). Tissue hypoxia is the basis for this and is more likely the result of circulatory inadequacy (e.g., decreased cardiac output and secondarily decreased perfusion rates) than of ventilatory insufficiency, since P_{CO_2} values are maintained within normal ranges. But such P_{CO_2} values are abnormal when considered together with the metabolic acidosis. In any event, PO_2 values are generally low and these changes will result in less saturation of the hemoglobin. The hypothermia itself will shift the oxygen hemoglobin saturation curve to the left (the P_{50} shifts to the left) so that unloading will occur at lower tissue PO_2 values. This may be offset to some extent by the counter shift produced by the reduced pH. It is not known what the effect of hypothermia on the role of 2,3-diphosphoglycerate may be. A further impediment to tissue oxygenation (decreased flow) is the increased viscosity of blood caused by sludging. Finally, the oxygen content of the blood must be taken into account as well as the PO_2 and the degree of saturation of the blood (which probably will be incorrectly reported if the laboratory carries out the determination at normal body temperature). An anemic patient will have a smaller oxygen content of his arterial blood than a patient with a normal hemoglobin concentration at the same PO_2 . The only way to assess the level of tissue hypoxia is to determine the pH, PO_2 , PCO_2

and the oxygen content of mixed venous blood.

The cardiovascular changes brought about by hypothermia are several and complex. Initially, as in our first patient, there may be tachycardia which results from shivering and from sympatho-adrenal stimulation. Later, bradycardia is the rule as the hypothermia deepens. Cardiac output decreases because of the increased peripheral resistance, the bradycardia and a mean arterial pressure which may be maintained but often declines (first patient). In the electrocardiogram the PR, QRS, and QT (corrected for rate) intervals all are prolonged. The most characteristic changes are those affecting the QRS complex and the early part of the ST segment. This is the J or junctional wave (see Figure 3) reported as early as 1938 by Tomaszewski⁴ and sometimes called the "Osborn wave," after Osborn who carried out extensive studies in experimental animals.⁵ Although a characteristic found in hypothermia, as indicated by Emslie-Smith,⁶ it is not necessarily an indication of impending ventricular fibrillation. Much more serious are the arrhythmias which can be atrial, as in our first patient, or ventricular in type. Ventricular fibrillation can occur spontaneously but also can be precipitated by invasive procedures such as intubation and catheterization. It is a significant probability when the core temperature falls to 30°C or lower.

In the central nervous system profound changes occur. Disorders of mentation and speech are noted first with loss of control of voluntary movements, muscle rigidity, and unconsciousness eventually occurring. In electroencephalograms, evidence of activity decreases with decrease of core temperature and effectively disappears at 18° to 15°C. Activity reappears on rewarming. Thus, a flat EEG cannot be taken as evidence of irreversible brain damage in hypothermic patients.

Other effects of hypothermia are not negligible. "Cold" diuresis may occur as a result of inhibition of antidiuretic hormone from the cold or from ethanol. More importantly, the perfusion problems result in decreased renal blood flow and glomerular filtration rate. Classical acute tubular necrosis may supervene. At the microcirculation level, there may be vasomotor paralysis, sludging, an increased blood viscosity and formation of microthrombi. Even disseminated intravascular coagulopathy may occur. Patients with cryoglobulins or cryofibrinogen may be at particular risk.

Management—Although there is agreement that hypothermic patients should be rewarmed, there is disagreement as to means and as to how rapidly. Additional supportive or therapeutic interventions may be required by the other underlying problems of the patients.

Spontaneous rewarming is one means but is limited by endogenous heat production which may be depressed markedly. However, if this course is chosen heat losses are reduced by covering the patients with blankets and by putting them in an environment which in the United States will at least be in the vicinity of 70°F (21.1°C) and presumably warmer than the environment from which the patient was removed. Room temperatures of 25° to 32°C (77° to 90°F) obviously will accelerate rewarming.

Active rewarming covers any means which add exogenous heat to the patient. Modalities available include: electrically and fluid-heated blankets, immersion in hot water at 42°C or 107.6°F maximum,[†] peritoneal dialysis with warmed fluids, cardiopulmonary bypass, and hemodialysis. Disadvantages include respectively: local overheating,

vasodilation sufficient to produce circulatory collapse unless only trunk is immersed, invasive procedure with possibility of infection, requirement for not always available technological capability, with the possibility of vascular damage.⁸

No simple all-encompassing recommendations can be made about the management of patients with hypothermia because adequately controlled studies have not been carried out. The following appear to be reasonable:

- (1) Temperatures below 30°C require active rewarming because of the danger of ventricular fibrillation.
- (2) The rate of rewarming should be as rapid as possible for core temperatures below 30°C and at a rate of 1° to 2°C per hour above 30°C.
- (3) In elderly patients, a rewarming rate of 0.5°C per hour probably should not be exceeded when the core temperature is above 30°C.
- (4) Attempts at electrical defibrillation should not be made at temperatures below 28°C; defibrillation is unlikely to be successful until the temperature rises above 30°C.
- (5) Ancillary supportive measures should be carried out as indicated and required. These include correction of metabolic acidosis (cautious intravenous administration of sodium bicarbonate with reassessment after every 44mM). As shown by Osborn⁵ in experimental animals, ventricular fibrillation is more likely when the bicarbonate concentration is reduced. Oxygen should be administered if the P_O₂ and oxygen content are decreased. Packed red cells should be infused cautiously if the patient is significantly anemic. Hypoglycemia should be corrected but administration of fluids should be undertaken cautiously. Antibiotics should be used if indicated but not prophylactically. Steroids are of uncertain benefit and are not indicated although not specifically contraindicated. Vaso-active drugs are contraindicated because they may interfere further with tissue perfusion and because they may precipitate cardiac arrhythmias.

Prognosis—In Table 1, I have taken the data for external rewarming summarized by Gregory and Doolittle⁹ with the data of Hudson and Conn¹⁰ and those of Weyman, Greenbaum and Grace¹¹ and have included the two patients recorded here. A comparison of active and passive rewarming procedures with respect to outcome is given in Table 2. Outcome data appear to be related to the degree of hypothermia, mortality being lowest with the highest measured admission temperatures. When the data of Table 1 are lumped with respect to deaths or survivals and passive or active rewarming, the differences in outcome between passive or active rewarming are not significant. Active rewarming was used somewhat more frequently in the patients with severe hypothermias (58 percent). The higher mortality rates in the actively rewarmed group probably reflect the presence of severe underlying disease (such as diabetic ketoacidosis, gastrointestinal hemorrhage, pancreatitis). Thus on pooling the data of Weyman *et al.*¹¹ and of Hudson and Conn¹⁰ and on dividing the patients into a group without severe complications and a group with severe complications (mostly alcoholic individuals) one finds the following. There were two deaths out of 38 patients (mortality rate 5.3 percent) in the group without complications while there were 13 deaths out of 16 patients (mortality rate 81.3 percent) in the group with complications, more of whom were rewarmed actively.

SUMMARY

In brief, it appears that prognosis is related to the degree of hypothermia and, for equal degrees of hypothermia, to

[†]Keatinge⁷ recommends a temperature as high as 45°C or 113°F.

Table 1
Patient outcome with external rewarming^a

Degree of hypothermia	C°	Passive		Active		Totals		
		Died	Survived	Died	Survived	Died	Survived	All
"mild" (94.9 – 90.0°F)	34.9 – 32.2	4	19	13	17	17	36	53
"moderate" (89.9 – 80.0°F)	32.1 – 26.7	38	52	33	25	71	77	148
"severe" (≤79.9°F)	≤26.6	12	10	19	11	31	21	52
TOTALS		54	81	65	53	119	134	253

^a Footnote to Table 1 – The data reported include the summary of Gregory and Doolittle⁹, the data of Hudson and Conn¹⁰, the data of Weyman, Greenbaum and Grace,¹¹ and the two patients reported here.

Table 2
Mortality rates as percentages

Degree of hypothermia	Passive	Active	Overall
"mild"	17.4	43.3	32.1
"moderate"	42.2	56.9	48.0
"severe"	54.5	63.3	59.6
Overall	40.0	55.1	47.0

whether or not there is an underlying complicating disease. That active rewarming does not show a more beneficial effect on survival may be due to its greater use in the more severely ill patients. While active rewarming is probably always appropriate, the type of rewarming to be used is still under examination. External rewarming can be carried out under almost any circumstances and generally is available. Core rewarming, whether by peritoneal dialysis, hemodialysis or by other means, requires more advanced technology and is, in my opinion, not indicated for core temperatures above 30°C. There is, admittedly, growing enthusiasm for core rewarming probably because of the increasing availability of the required technology. I hope, but dare not expect, that adequately controlled studies will be carried out. The one positive aspect of this enthusiasm is that the hypothermia is brought into focus rather than its subsidiary manifestations.

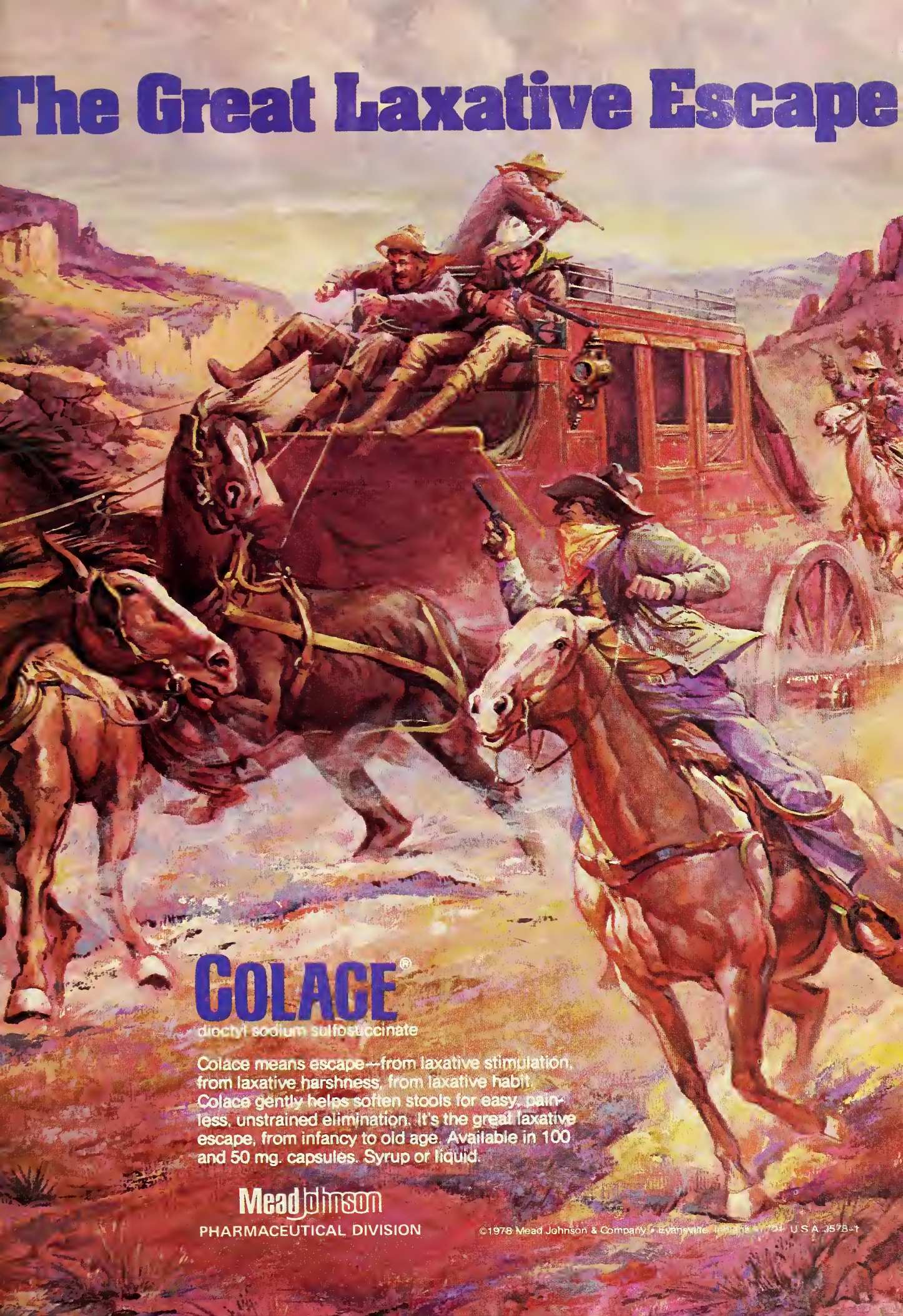
ADDENDUM

Since this manuscript was submitted several publications have appeared bearing on the methods to be used for rewarming. Thus, Soung *et al.*¹² state that "peritoneal dialysis, hemodialysis, and partial cardiopulmonary bypass are relatively simple methods of internal rewarming that are readily available in most hospitals." On the basis of their one published incident they recommend peritoneal dialysis. A more dispassionate view is taken editorially by *The Lancet*¹³ which concludes: "at present no method for routine use offers clear advantages over surface rewarming." This view is supported in the "Letters to the Editor."¹⁴ Attention also is drawn to the recent editorial by Vaisrub.¹⁵

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Gout in an Urban Setting

JOAN K. KOWALEC, M.D. AND
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Over a 21-month period forty-two patients with acute gouty arthritis were seen at the Martland Medical Center in Newark. Ninety percent of patients were black and a large percentage (22 percent) were women. Subcutaneous tophi occurred in 24 percent and hypertension, chronic alcohol ingestion, renal disease, and diabetes were associated disorders in decreasing incidence in both men and women. The incidence of gout in blacks, especially women, is compared to other reported series. The 75 percent loss of patients to follow-up care is discussed with respect to possible methods of promoting patient return and improving maintenance and prophylactic care in this urban setting.

Gout, now one of the most treatable of all the rheumatic diseases, is also a relatively easy disorder to diagnose. The clinical picture of a middle-aged male with an acute monoarthritis, hyperuricemia, and a history of podagra has been the prototype for centuries. Other presentations such as subacute polyarticular attacks or acute forms of arthritis especially in women have not been identified easily as gout. Since 1961, however, when McCarty and Hollander rediscovered precipitated monosodium urate crystals in the synovial fluid of affected joints,¹ the diagnosis of gout can be precise. The following report deals with those patients seen over a 21-month period at the Martland Medical Center in Newark who were diagnosed as having acute gouty arthritis.

MATERIALS AND METHODS

All of the patients were studied during the period from December 1975 to August 1977. Ninety percent were hospitalized, the remainder was seen in the Rheumatology Clinic. In 81 percent of the patients, the diagnosis was based on the identification of monosodium urate (MSU) crystals in the synovial fluid or in material extracted from a tophus; in the remainder, the diagnosis was made from a history of either podagra or other acute joint inflammation associated with hyperuricemia. Synovial fluid analysis was carried out as described previously,² crystals being identified with a polarized, compensated microscope.

The patients were evaluated clinically at the time of the acute gouty attack, and additional past historical data were gathered from the patients' hospital charts. With respect to associated disorders the available records of 34 patients were considered adequate for inclusion in this study.

RESULTS

Forty-two patients were diagnosed as having acute gouty arthritis. The majority of the patients were black; 31 of the 33 men and seven of the nine women (Table 1). In twenty-four patients the age of onset could be determined with some reliability and averaged 52 and 53 years in men and women respectively.

Most of the patients presented with an acute arthritis usually involving the knees, ankles, or the small joints of the feet, especially the first metatarsophalangeal (MTP) joint. Thirty-one percent had acute polyarticular attacks: One patient was admitted with six inflamed joints (left elbow, right wrist, left knee, both ankles and right first MTP) and

*From the Department of Medicine, Division of Rheumatology, New Jersey Medical School, CMDNJ, Newark, where Dr. Kowalec is Subspecialty Resident in Rheumatology and Dr. Krey is Director of Rheumatology and Associate Professor of Medicine. Funds in support of this study were obtained from the New Jersey Chapter of the Arthritis Foundation. Presented at the New Jersey Regional Meeting, American College of Physicians, November 9, 1977. Requests for reprints should be sent to Dr. Krey at the College, 100 Bergen Street, Newark, New Jersey 07103.

Table 1
Gouty Arthritis
Sex and Race Distribution of Forty-Two
Patients at Martland Medical Center

Total Men		33
Black	31	
White	2	
Total Women		9
Black	7	
White	2	
Ratio Men:Women		3.7:1

Table 2
Gout
Associated Disorders in Patients at
Martland Medical Center

Disorders	26 Males (Percent)	8 Females (Percent)
Hypertension	54	50
Cardiac Disorders	19	12
Diabetes	19	38
Renal Insufficiency	12	38
Cerebrovascular Accident	12	—
Alcoholism	42	38
Tuberculosis	4	—
Chondrocalcinosis	4	—
Paget's Disease of Bone	4	—

Table 3
Synovial Fluid Findings in
35 Fluids containing Sodium Urate Crystals

No. of Fluids	Leukocyte Count per mm ³	Average Neutrophil Percentage	Percent Abnormal Mucin Clots
0	0 — 200	—	—
6	200 — 2500	39	50
20	2500 — 25,000	72	100
9	25,000 — 50,000	85	100
0	> 50,000	—	—
Total	35	Average 70	92% Abnormal

ulcerating tophaceous deposits requiring surgery and skin grafts for both MTP joints. Another patient required surgical removal of large draining tophi from the elbows and a third patient needed resection of a gouty first MTP joint because of chronic irritation and inflammation. The overall incidence of tophaceous deposits in this group of patients was 24 percent (seven men and three women).

Table 2 depicts the associated disorders found in these patients. Hypertension was found frequently in both men and women and chronic alcoholism was common. Compared to men more of the women had renal disease and diabetes. Three men had had cerebrovascular accidents and three males each had tuberculosis, Paget's disease of bone, and chondrocalcinosis. The latter patient did not have a simultaneous attack of pseudogout.

The synovial fluid findings are recorded in Table 3. Most specimens fell into the Group II or "Inflammatory" synovial fluids with leukocytes ranging from 2500-50,000 per mm³ and with polymorphonuclear percentages averaging 70 percent. Usually fluid specimens with low white cell counts (17 percent) had few crystals and needed longer search under polarized light while those with high white cell counts had more crystals, easily identified in many high power fields. Most crystals were intracellular but some were free in the synovial fluid. Mucin precipitates (hyaluronate-protein complexes precipitated with 2 percent acetic acid) were abnormal in 92 percent of fluids and rated either fair or poor.

A few patients were difficult to diagnose. For example, a 50-year-old black male with well-controlled hypertension entered the hospital with an acute right knee effusion; he gave a history of recurrent swelling and tenderness of the metacarpal and proximal interphalangeal joints of his hands over a period of eight years. Although he had had multiple acute attacks of swelling and pain in his large joints, he denied podagra and his joints had never been tapped. Gout had never been mentioned to him. His serum uric acid was 9.7mg/dl on admission (upper normal limit 8.4mg/dl). Fluid

removed from his knee showed a 17,000 white cell count with 72 percent neutrophils and a poor mucin clot, but no sodium urate crystals in spite of diligent search by several observers. He was prescribed high dose salicylates, 6 grams a day, and two days later he experienced acute swelling and tenderness in his other knee. Aspiration of this fluid revealed the typical birefringent needle-shaped crystals of sodium urate. Oral colchicine and later indomethacin improved the patient's arthritis within a few days.

Another patient, a 76-year-old black woman, was told that she had rheumatoid arthritis and was taking aspirin in low doses for more than twenty years. Hard, symmetric joint swellings were present in her distal and proximal interphalangeal joints, and ulnar deviation of her hands was marked. She had multiple, firm and lumpy nodules in her hands, elbows, ears and Achilles tendons, confirmed by aspiration to be tophaceous deposits. Swelling and acute tenderness were present in one knee and one MTP joint; serum uric acid was 10.8mg/dl. Chronic renal failure was present with bilateral hypoplasia demonstrated by intravenous urography. She denied any renal colic, hypertension, or alcohol abuse. After having one child at age 19, her menstrual periods had ceased at age 22. Her mother had had gout. Following admission, the acute arthritis was controlled with indomethacin; the patient was discharged on prophylactic colchicine and allopurinol. She died six months later at home of a probable cerebrovascular accident. She had not kept any of her clinic appointments for follow-up of her gout.

DISCUSSION

This series of patients with gout is of interest because of the large number of black patients and a high proportion of women. There have been few studies of gout in the black race probably because of the generally held impression, expressed by Hench in 1940, that "gout is rare in colored people."³ In 1953 a comparison of white and black male patients admitted

Table 4
Gout in Black Men: Associated Disorders

	Talbott et al 1975	Kowalec and Krey 1978
Year	43	31
Number of Patients		
	P e r c e n t	
Tophi	42	21
Hypertension	49	54
Cardiac and Cerebrovascular Disease	—	31
Renal Disease	53	12
Diabetes	14	19

Table 5
Gout in Women: Associated Disorders

Reference Numbers	(9) R & G	(17) G & S	(6) Talbott	(10) Yu	Present Study K & K
Year of Study	1958	1970	1975	1977	1978
Number of Women	7	35	22	108	9
Number of Black Women*	7	0	22	6	7
	P e r c e n t				
Tophi	66	21	14	38	33
Hypertension	56	52	50	36	50
Cardiac & Cerebrovascular Disease	—	15	—	22	12
Renal Disease	86	25	45	60	38
Diabetes	—	—	5	—	38

* The majority of the remaining women were white.

to Cook County Hospital in Chicago indicated that the white males had twice the incidence of gout.⁴ Six years later, however, Turner *et al.* concluded that no significant racial differences in the incidence of gout exist since their series of 45 black patients paralleled the general hospital population.⁵ Talbott *et al.* emphasized the universal nature of gout in a recent review of 65 black patients with gout.⁶ Table 4 compares their findings in men with ours. The incidence of hypertension and diabetes is similar but renal disease appears more common in their patients. Talbott and his colleagues suggest several factors which may place blacks at a greater risk for developing gout: the increased frequency of hypertension and diuretic therapy which suppresses the excretion of uric acid; the higher incidence of tuberculosis and the use of pyrazinamide; and the association of sickle cell disease and hyperuricemia. Interestingly, neither of the latter two potential risk factors appear to play an important role in Talbott's or in our own patients.

Gout in white women has always been uncommon, most studies placing the incidence at 3 to 7 percent.⁷ Our incidence of 19 percent black women having gout (of total black patients) was surprising until we compared our findings with those reports in which blacks comprise at least 50 percent of the group studied. Salzman, Howell, and Ricca,⁸ Turner *et al.*,⁵ and Talbott *et al.*⁶ found a remarkably similar incidence of 33, 31 and 33.8 percent respectively. Rodnan and Golomb⁹ first drew attention to gout in black women in 1958. Four of the seven patients had tophi and six had renal disease. Table 5 summarizes reported studies of both black and white women with gout.

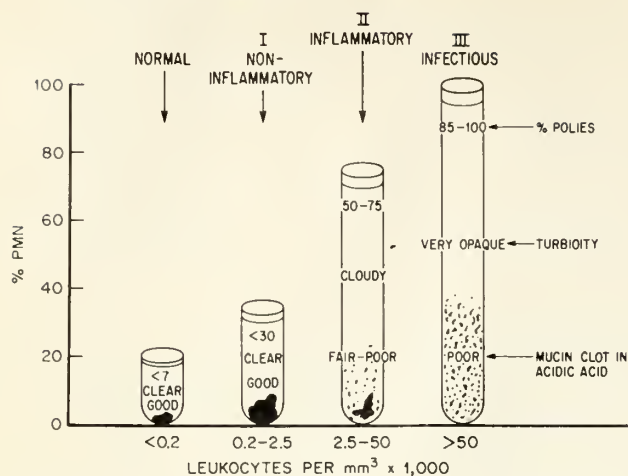
In a recent review of 108 women with gout (94 percent were white) Yu points out a premenopausal onset of the disease in those with a positive family history and a later onset in those women whose disease is more related to diuretic medication.¹⁰ Both Yu and Talbott draw attention to the fact that if one compares the number of offspring of

normal women, those who develop gout appear to be less fertile. The patient in our series with amenorrhea at age 22 and a history of gout in her mother suggests an endocrine abnormality. The remaining women in our study had the onset of gouty arthritis at an average age of 53 years and fifty percent had hypertension, suggesting that these patients had a secondary form of gout.

The results of our synovial fluid findings are not unexpected. In the absence of a specific finding such as crystals or microorganisms, it is conventional to group synovial fluids by the leukocyte count and neutrophil percentage into non-inflammatory (Group I), inflammatory (Group II) and infectious (Group III) as depicted in Figure 1.^{11,12} The fact that the inflammation within the joint space is directly related to the number of urate crystals in the synovial fluid has been pointed out by McCarty.¹³ In a previous study 82 fluid samples with MSU crystals were analyzed for extremes in leukocytosis and surprisingly, a quarter of these fluids had leukocyte counts below 2500 cells/mm³.² Without the presence of crystals many of these fluids would have been interpreted as "non-inflammatory" and would have suggested different diagnoses, especially since the patients had more subacute symptoms. At the other extreme of leukocytosis, 10 percent of specimens had over 50,000 cells/mm³. This again points out the value of crystal identification; without this finding these patients would have been thought to have possible infectious arthritis. Occasionally, as was seen in one patient, a fluid may appear to be false negative for crystals and initial therapy may not be optimal. The reasons for this are unknown but the major causes are probably technical.¹⁴

Presently available potent hypouricemic drugs can prevent tophaceous deposits, joint destruction, and possible kidney damage. The presence of tophi, usually the result of years of sustained hyperuricemia, reflects in part the quality of medical care, since it has been shown⁵ that adequate

CONVENTIONAL GROUPING OF SYNOVIAL FLUIDS



Conventional Grouping of Synovial Fluids—The synovial fluid leukocyte count per mm³ x 1000 is represented by the horizontal line and the height of the test tubes indicates the neutrophil percentage. The mucin precipitate in 2% acetic acid becomes more friable as the white cell count and inflammation increase.

treatment decreased the incidence of tophi over the years 1949-1973 from 53 to 17 percent.¹⁵ The incidence of gout, however, has remained the same. Another study over the same span of time showed a decrease in tophi from 14 to 3 percent.¹⁶

Seventy-five percent of our patients were lost to follow-up care; two of the patients returned only because of an acute attack of arthritis. To insure better medical care for patients in this urban setting efforts must be made to promote patients' return for follow-up care. This may be accomplished by (1) education of the patient as to the importance of care and the rationale for treatment, (2) maintenance of a registry of patients, (3) follow-up by a community worker who will seek out patients who fail to return to clinic, (4) subspecialty education of the primary physician especially as to diagnosis

in women, and (5) supervision of specially trained nurses to follow through on maintenance and prophylactic therapy.

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Drug-Resistant Tuberculosis

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The clinical presentation of drug-resistant tuberculosis is discussed and chemotherapy, management principles, and factors contributing to treatment failure reviewed. A successful method of supervised out-patient management is described in which fifteen treatment failures, more than 50 percent of whom had drug-resistant disease, were treated. Patient compliance in taking medications was 80 percent, and 94 percent achieved sputum negativity with no evidence of relapse.

Drug-resistant tuberculosis" is a term used clinically to describe cases of tuberculosis caused by infection with strains of *M. tuberculosis* that are not susceptible to the bacteriostatic or bacteriocidal effects of the currently available antituberculosis drugs.¹ The organisms may be resistant to one or multiple agents when they are administered in conventional dosages.

SPONTANEOUS DRUG RESISTANCE

Mechanisms involving the emergence of drug-resistant disease differ, and clinically, two distinctly different patterns of development are noted.² Populations of *M. tuberculosis* are not homogenous mixtures of mycobacteria that are identical in all aspects. For reasons which are not completely understood, mutants develop spontaneously which have numerous biological and biochemical characteristics that differ from most of the members of the population. These mutants will grow in the presence of concentrations of antituberculosis drugs which inhibit or kill the large majority of members of the original wild strain.

Primary drug-resistant tuberculosis occurs as the result of infection with spontaneously occurring drug-resistant mutants which are present in a predominantly drug sensitive population of *M. tuberculosis* prior to instituting treatment. In other rare instances, primary drug-resistant disease occurs as a result of infection with drug-resistant mycobacteria transmitted via the airborne route following contact with an

infectious case of drug-resistant tuberculosis. In any event, primary drug resistance is not considered to be attributed to prior treatment with antituberculosis drugs. Though some variations in the incidence of primary drug resistance exist, current evidence suggests that the overall level remains low, though significantly higher in younger than older patients.^{3,5}

ACQUIRED DRUG RESISTANCE

More commonly "drug-resistant tuberculosis" is acquired. Acquired drug resistance occurs in individuals who initially are infected with a drug-sensitive strain of *M. tuberculosis* but following the initiation of chemotherapy a significant number of the acid-fast population survive and multiply. Ultimately these drug-resistant organisms continue to multiply until they comprise the vast majority of the myco-

* From the Department of Medicine, Pulmonary Division, New Jersey Medical School, CMDNJ. Presented in part at the New Jersey Regional Meeting, American College of Physicians, November 9, 1977. Dr. McDonald is Assistant Professor of Medicine, New Jersey Medical School, Martland Hospital Unit, CMDNJ; Dr. Memon also is Assistant Professor of Medicine at the same institution; and Dr. Reichman, who is supported in part by the National Heart, Lung, and Blood Institute, Pulmonary Academic Award #5 K07 HL00124-05, is Professor of Medicine at the College and Director of the Pulmonary Division at the Martland Hospital Unit. The Comprehensive Pulmonary Disease Clinic is supported by the Tuberculosis Services Division of the New Jersey Department of Health. Correspondence may be addressed to Dr. McDonald, 15th floor, Pulmonary Office, Martland Hospital, 65 Bergen Street, Newark 07107.

bacterial population. Acquired drug resistance is therefore a consequence of treatment. Usually this form of drug-resistant tuberculosis occurs as a result of "therapeutic incompetence" or secondary to "social or behavioral maladjustment" and accounts for most cases of drug-resistant tuberculosis that are seen in this country.⁶ Several investigators have shown that adequate chemotherapy and patient cooperation (particularly in ingesting a prescribed drug regimen) are the most important factors influencing tuberculosis treatment response.⁷

TREATMENT

The selection of an adequate chemotherapeutic regimen in drug-resistant disease depends upon the potency and toxicity of the drugs available for use and upon the drug-susceptibility patterns of the infecting mycobacteria. A detailed history outlining the duration, frequency, and drug used in prior treatment will aid the physician in determining the type of drug resistance and in selecting a drug regimen for retreatment. Drug-susceptibility testing is a convenient method of demonstrating drug resistance and always should be done when initiating a treatment program for acquired drug-resistant disease.

Ideally, treatment should be instituted with at least two and preferably three of the most potent and least toxic of the antituberculosis drugs to which the mycobacteria are sensitive. It should be stressed that *"a single new potentially effective drug never should be added to a failing or failed regimen"* unless the drug-susceptibility pattern of the mycobacteria are known and the addition of a single drug is not likely to cause development of resistance.⁸

The so-called first-line drugs (table 1), isoniazid, rifampin, ethambutol, and streptomycin, remain the drugs of choice in treating drug-resistant tuberculosis when full susceptibility is demonstrated, because of their low toxicity and increased effectiveness.⁹

Because the first-line drugs are used frequently in initial treatment, mycobacteria not uncommonly are demonstrated that are resistant to their effects either as single drugs or in various combinations rendering their use inappropriate for treatment of drug-resistant disease. When the first-line drugs are judged inadequate for use, several second-line (table 2) drugs are available for use. These include four oral and three injectable agents. Pyrazinamide, ethionamide, PAS, and cycloserine are given orally and capreomycin, viomycin, and kanamycin are given parenterally. When used under

conditions of full susceptibility, viomycin's antituberculosis activity has been reported to be somewhat less potent than the other parenteral agents. Of the oral agents, PAS and cycloserine are reported to be less effective.

PATIENT COMPLIANCE

Patient cooperation in ingesting a prescribed drug regimen is equally as important as chemotherapy in the treatment of tuberculosis. Irregular self-administration of medications is a significant problem in the out-patient management of tuberculosis where patients frequently become asymptomatic but require regular drug taking for extended periods of time.¹⁰⁻¹¹ Lack of patient cooperation in the self-administration of drugs is the single most important factor responsible for the emergence of drug-resistant tuberculosis.

The reasons for poor self-administration of medications vary. In some instances, cultural or ethnic backgrounds present barriers to patient education. The systems which are designed to provide care, in some cases, tend to frustrate and humiliate patients. Frequently, psychosocial maladjustments such as sociopathic personality and chronic alcoholism are responsible.

One approach to the problem of poor self-administration of medications, which has proved effective, is the supervised administration of drugs. In our own institution this approach has been used in several cases of tuberculosis treatment failure in which poor self-administration of drugs was identified as probably being causative. Fifteen patients thus far have been studied (12 males, 3 females), all of whom have a long (mean 26 months) history of unsuccessfully treated tuberculosis and a high percentage (73 percent) had problems relating to chronic alcohol abuse. In addition, more than half (53 percent) demonstrated organisms that were resistant to one or more antituberculosis drugs.

Reasoning that a concentration of drug-delivery effort in the early phases of treatment offered the best opportunity for success, a treatment program was devised which consisted of an initial six-month period of supervised administration of at least one injectable and two oral antituberculosis drugs to which the patient's organisms were sensitive, followed by continuation of an unsupervised oral drug regimen for as long as possible, in most cases 18 months. Treatment was conducted on an ambulatory basis and the programs of drug delivery were flexible. Patient compliance during the initial six months of supervised therapy was 80 percent, and sputum

Table 1
First-Line Drugs

Drug	Dosage	Side Effects	Monitoring	Remarks
Isoniazid	5-10 mg/kg up to 300 mg PO or IM	Peripheral neuritis, hepatitis, hypersensitivity	SGOT/SGPT (not routine)	Bactericidal; far neuritis, pyridoxine, 10 mg as prophylaxis; 50-100 mg as treatment daily.
Ethambutol	15 mg/kg PO	Optic neuritis, (reversible with discontinuation of drug; very rare at 15 mg/kg); skin rash	Red-green color discrimination and visual acuity	Use with caution in renal disease or when eye testing is not feasible.
Rifampin	10-20 mg/kg PO, up to 600 mg	Hepatitis, febrile reaction, purpura (rare)	SGOT/SGPT (not routine)	Bactericidal; orange urine color, benign.
Streptomycin	15-20 mg/kg up to 1 g IM	8th nerve damage, nephrotoxicity	Vestibular function, audiograms, BUN, and creatinine	Use with caution in older patients or those with renal disease.

Table 2
Second-Line Drugs

Drug	Dosage	Side Effects	Monitoring	Remarks
Vicomycin	15-30 mg/kg up to 1 g IM	8th nerve damage, nephrotoxicity, vestibular toxicity (rare)	Vestibular function, audiograms, BUN, and creatinine	Use with caution in older patients; rarely use with renal disease.
Capreomycin	15-30 mg/kg up to 1 g IM	8th nerve damage; nephrotoxicity	Vestibular function, audiograms, BUN, and creatinine	Use with caution in older patients; rarely use with renal disease.
Kanamycin	15-30 mg/kg up to 1 g IM	8th nerve damage, nephrotoxicity, vestibular toxicity (rare)	Vestibular function, audiograms, BUN, and creatinine	Use with caution in older patients; rarely use with renal disease.
Ethionamide	15-30 mg/kg up to 1 g PO	Gastrointestinal, hepatotoxicity, hypersensitivity	SGOT/SGPT	Divided dose may help GI side effects.
Pyrazinamide	15-30 mg/kg up to 2 g PO	Hyperuricemia, hepatotoxicity	Uric acid, SGOT/SGPT	Combination of pyrazinamide and aminoglycoside is bactericidal.
Para-amino-salicylic acid	150 mg/kg up to 12 g PO	Gastrointestinal, hypersensitivity, hepatotoxicity, sodium load	SGOT/SGPT	GI side effects very frequent, making cooperation difficult.
Cycloserine	10-20 mg/kg up to 1 g PO	Psychosis, personality changes, convulsions, rash	Psychologic testing	Very difficult drug to use. Side effects may be blocked by pyridoxine, ataractic agents, or anticonvulsant drugs.

negativity was achieved in 94 percent of patients. No evidence of relapse has been noted in any patient, with a mean follow-up of 19 months.

CONCLUSION

It is our belief that tuberculosis treatment failures including many with drug-resistant tuberculosis can be treated effectively as out-patients when flexible programs of drug delivery are utilized.

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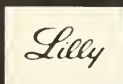
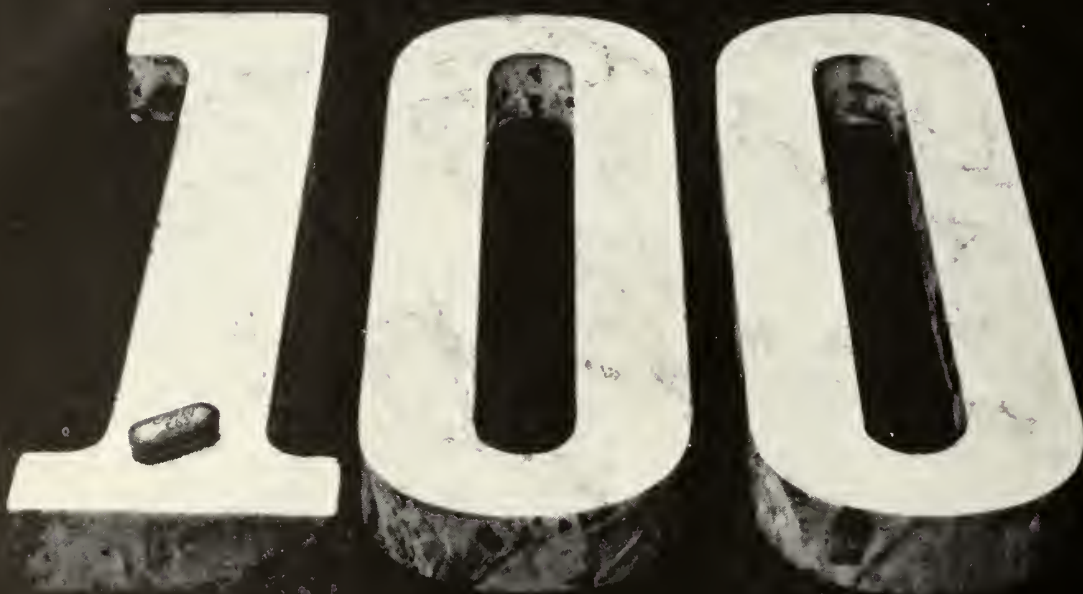
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Rev. Stephen Hales, D.D., F.R.S. (1677-1761)

HARRY BLOCH, M.D., South Orange*

In the 18th century, the Royal Society, founded in 1660, convinced natural philosophers to explore "the fabric of nature." Talented laymen made notable contributions. Rev. Stephen Hales, pastor of St. Mary's-in-the-Meadows and curate of Teddington, Middlesex, was one of them.¹

Hales lived in the "age of reason based on faith" and, like Robert Boyle (1627-1691), believed that "exploration of His handiwork revealed the wisdom of the Almighty"—a theme likewise explored in *Religio Medici* by Sir Thomas Browne (1624). In his student days at Cambridge, Hales manifested profound interest in natural history and, as a parish priest, made distinguished contributions to respiratory and cardiovascular physiology.^{2,3,4}

Anatomy and physiology of heart and blood vessels, as interpreted by Galen (131-201 A.D.), prevailed until mid-16th century: porous interventricular septum; the liver formed red blood cells; veins carried nutritive blood from liver; the heart and arteries constituted a ventilating and heating system; and arteries pulsed. Erosion of these theories began with the anatomist Vesalius (1514-1565) who showed that Galen had only dissected animals; it was completed by the physiologist William Harvey (1578-1657). Harvey proved that the heart and arteries were a sanguinous and not a pneumatic system; that the heartbeat regulated the velocity and movement of blood, which reached the lungs by way of the pulmonary artery and all parts of the body via

the aorta.[†] Arteries did not pulsate, but were distended with each ejection of blood from the left ventricle and passed down the aorta and its branches as a pressure pulse wave that moved at a much faster rate than blood flow; the auricles received blood during diastole from the vena cava and pulmonary veins; arterial blood nourished the body; and blood flowed from all parts of the body to the heart. Marcello Malpighi (1628-1694) saw capillaries under his microscope 33 years later, and completed Harvey's discovery of blood circulation.^{5,6,7}

This was the total of cardiovascular physiology when Hales began scientific experimentation in 1708. Twenty-five years later, he published his findings, *Hemastaticks*, considered by Johannes Mueller (1801-1858) of equal importance to "De Motu Cordis."^{3,8} Hales' treatise founded hemadynamics and qualified him as the "Father of Blood Pressure." He introduced methods of experimentation and quantitation, showed the importance of repeated experimentation for confirmation, and insisted: "We cannot depend on speculation . . . to make . . . advances. . . ." ^{2,9,10}

Hales was the first to measure blood pressure, the volume and capacity of the heart, the velocity of the blood current in the veins, arteries, and capillaries, and to investigate the

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†Aristotle also thought heart and arteries transmitted blood.

peripheral circulation and properties of capillaries.^{3,5,9} With perfusions of periperal vessels, he proved that the flow of blood varies in capillaries: warm perfusions increased the flow by capillary dilatation; cold slowed it by constriction; and the resistance to blood flow was greatest in the capillaries. Hales showed that the velocity of the blood in the aortic column, 86.7 feet per minute, was generated by ventricular systole, and that the speed of blood flow differed from the pressure pulse wave in form and nature.³

Both Harvey and Borelli (1608-1679) had observed severed blood vessels: some dripped, others spurted. Hales investigated this phenomenon and made pressure determinations on a mare "... 14 hands high and 14 years of age. ..." Rubber tubing (a 19th century invention) was not available so he used a goose's trachea joined at one end to a glass manometer and to a brass pipe in the carotid artery at the other. He saw blood rise eight to nine feet and vary one to three feet with each ventricular contraction. He connected his apparatus to the jugular vein and observed blood rise to less than one foot, a difference due to blood force in minute vessels. Hales calculated man's blood pressure at seven and one-half feet (actually five to six feet) and exerted pressure on blood vessels of two and one-half pounds per square inch. He wrote, "... I took away the glass tube and let the blood ... mount up in open air ... the greatest height ... was not above two feet." He estimated force of the heart beat to be 51 pounds, as contrasted to Borelli's 180,000 pounds and James Kiel's (1673-1719) 5 ounces.^{2,5,9,10}

Hales noted changes in blood pressure and heart rate under varying conditions; after food and rest, the state of the blood, the cardiac output, the velocity of blood entering the aorta with each systole, and the quantity passing through the capillaries. When variable amounts of blood were removed, the pressure was "much abated with each unit removed"; with abdominal compression the blood pressure increased. He observed that constriction of blood vessels with perfusions of cold water in the aorta and dilatation with warm water also produced outflow differences.⁵

A simple experiment by Hales clarified the heart output. He filled the left ventricle of a horse with beeswax, found the volume to be 160 c.c. and computed the output was six litres per minute. Since man's volume was two ounces, he concluded the output of the human heart was four litres per minute.⁵

A century later, a young French medical student, Poiseuille (1799-1869), introduced a U-shaped mercury manometer and measured the rise and fall of the blood pressure with respiration, and arterial distension with each heart beat. He also demonstrated that capillary outflow depended on arterial pressure and inflow. In 1835, J. Herison invented the sphygmomanometer; J. Faivre, in 1853, connected a mercury manometer to an artery and made the first accurate blood pressure determination in man; Riva-Rocci, in 1896, introduced the cuff and rubber bulb. Carl Ludwig (1816-1895) invented the kymograph and recording manometer.^{5,9}

Respiratory physiology began with Galen. He asserted that respiration cooled the heart: chest movements brought air to the left ventricle, where "vital spirits" were generated, and exhaled "smoky vapours." Robert Boyle (1627-1691) breached this sophistry by proving experimentally the role of air in respiration, combustion, and maintenance of life. When he removed air, a lighted candle was extinguished and an animal died. He declared that air cooled the blood as it passed through the lungs; that blood passed substances into the lungs; and that air was contained in water, since



Hales measures blood pressure. (Source of drawing unknown)

gills of fish separated air from water. Boyle's pupil, Richard Lower (1631-1674), discovered that blood takes up air and gives it color (1669); and John Mayow (1640-1674) observed air in a vessel was reduced during respiration.

Hales pioneered quantitative gasometry. He measured air volume, the amount absorbed in breathing; and the rate of blood flow in lung capillaries of the frog, which he found "vastly greater than through other parts of the body." He showed that the site of air absorption was the alveolo-capillary membrane; and that the influence of respiration on atmospheric air in a container was reduction of volume, change in nature, and loss of property to maintain life. Mayow showed this before Hales, while Joseph Black (1728-1799), the first to prepare CO₂, confirmed this finding after him. Hales devised a method to collect gas over water and to measure air volume. It was done more efficiently over mercury by Henry Cavendish (1731-1810), who discovered hydrogen, and by Joseph Priestly (1733-1804) who rediscovered CO₂, and isolated O₂ (1774) and nitrogen (1775). Priestly demonstrated that oxygen is given off by plants—a gas in which a candle burns brighter and is essential for life.^{5,10-12}

CONCLUSION

Rev. Stephen Hales, faithful to church and science, made contributions to science by experiment and quantification. For loyal service to religion, Oxford conferred the degree of Doctor of Divinity (1773). For devotion to scientific experimentation, the Royal Society conferred fellowship and the Copley Medal (1739); and the French Academy of Science awarded its coveted membership (1753). For both, a monument was erected in Westminster Abbey.

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THERAPEUTIC DRUG INFORMATION

This information is compiled by the Schwartz Inter-National Pharmaceutic and Therapeutic Drug Information Center of the Brooklyn College of Pharmacy, Long Island University.*

1. Please provide information about the effectiveness of the new contraceptive Encare Oval.*

Encare Oval* (Eaton-Merz) is a nonhormonal vaginal foaming suppository that is claimed to prevent pregnancy in 99 of 100 women who used the contraceptive over a one-year period.

The product is advertised as having dual contraceptive properties: spermicidal activity and formation of a protective spermicidal barrier. The spermicidal component, nonoxynol-9, is available in other over-the-counter contraceptive agents including Delfen Foam*, Emko Vaginal Foam*, and Koromex Foam*. The physical protective barrier which forms over the cervical os results from the effervescence of sodium bicarbonate, tartaric acid, and polyethylene glycols.¹

Claims by the manufacturer concerning the effectiveness of Encare Oval are based on two German studies,^{2,3} but are being questioned by the FDA Contraceptive/Vaginal Advisory Panel (O.T.C.).⁴ The Panel is requesting further information to substantiate the efficacy of the product and that the barrier without the spermicidal agent prevents conception.⁵

Presently there are no studies comparing pregnancy rates of different vaginal contraceptive forms under the same clinical setting. Homm, *et al.*⁶ studied the efficacy of over-the-counter spermicidal products containing nonoxynol-9, using an *in-vivo* rabbit vaginal contraceptive model. It was found that an aerosol foam preparation containing 12.5 percent nonoxynol-9, on a milligram basis, was the most potent contraceptive tested. The solid dosage form products, including Encare Oval*, were the next most potent *in-vivo* contraceptive formulation. A cream containing nonoxynol-9 was third in potency ranking. When these products were compared for *in-vitro* potency against human sperm, the

Encare Oval* had the *lowest* spermicidal activity on a milligram basis.

In conclusion, Encare Oval* contains a spermicidal agent that has been available in several popular contraceptive foam products. Efficacy claims by the product's manufacturer are under investigation. An *in-vitro* experimental model indicated that a foam formulation of nonoxynol-9 was more potent a contraceptive than solid dosage form products including Encare Oval.*

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- ³Brehm H and Haase W: The alternative to hormonal contraception? Importance and reliability of a foam ovoid for vaginal contraception, *Med Welt* 26:1610, 1975.
- ⁴Anon: F.D.C. Reports, The Pink Sheets, 39:12 (Oct. 17) 1977.
- ⁵Anon: F.D.C. Reports, The Pink Sheets, 39:6 (Nov. 7) 1977.
- ⁶Homm R, *et al.*: A Comparison of the *in-vivo* contraceptive potencies of a variety of marketed vaginal contraceptive dosage forms, *Curr Ther Res* 22:588-595 (Oct.) 1977.

2. In response to numerous daily questions concerning Vitamin B₁₅ the following information is provided.

Vitamin B₁₅, also known as pangamic acid and diisopropylammonium-dichloracetate, has been available for the last few years in health food stores in tablet form under various trade names including Aankamik* 15, Gluconic* 15, and Calpang* 15. It is derived from apricot kernels and rice bran, and is ubiquitously found in seeds, brewer's yeast, ox blood, and horse liver. Evidence suggests its occurrence wherever other members of vitamin B complex are found.¹

Recently Vitamin B₁₅ has been widely publicized in the lay press for treatment of cardiovascular and rheumatic diseases, and has been claimed to possess action in oxidative and transmethylation metabolic processes.² It has also been claimed useful in the treatment of hypoxia, cerebral, and coronary sclerosis.³

A thorough search of the literature shows there is a paucity of scientific information or clinical studies concerning this agent. In a German study, Albach² treated 121 patients with chronic compensated liver damage, angina pectoris, and psychosomatic syndromes for over three months with an active fission product of Vitamin B₁₅ (Oxy-pangam*) at a dosage of 90 to 180 mg per day, given in divided doses. His results claimed a statistically significant

*The Center serves as a source of intelligence on therapeutic and pharmaceutic information not readily available to physicians, at no charge to them, and provides this information with minimal time involvement. It is staffed by trained pharmacists; Jack M. Rosenberg, Pharm. D., Associate Professor and Chairman, Division of Clinical Pharmacy, Brooklyn College of Pharmacy, is Director and Walter Modell, M.D., Emeritus Professor of Pharmacology at Cornell University Medical College, is pharmacologist consultant. The service is available Monday through Friday from 9 a.m. to 4:30 p.m.—telephone (212) 622-8989 or 303-2735. Responses to these questions were prepared by J. M. Rosenberg, M.S., Pharm.D.; A. Bakst, Pharm.D.; P. Sangkachand, M.S., R.Ph.; Doris Lau, B.S.

improvement of appetite and diuresis in hepatitis, suppression of pain and anxiety in angina pectoris, and elimination of various disturbances in patients with psychosomatic symptoms.

In conclusion, the significance of Vitamin B₁₅ in human nutrition remains to be established. No significant information was found to support the therapeutic claims made in the lay media.

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¹Stecher PG (editor): *The Merck Index*. Rahway, New Jersey, Merck & Co., Inc., 1960, p. 1099.
²Albach von E: Oxypangam. *Munch Med Wochenschr* 113:54-7 (Jan. 8) 1971.
³Anon: Rote Liste, Bundesverband der Pharmazeutischen Industrie, Frankfurt am Main, Germany, 1976, p. 36-073.

3. Recently the value of vitamin C as a urinary acidifier has been challenged. Do you have any information concerning its value?

Ascorbic acid is recommended as one of the adjunct urinary acidifiers during methenamine mandelate (Mandelamine[®]) and methenamine hippurate (Hiprex[®]) therapy, because an acid urine is essential for antibacterial activity of these compounds with maximum efficacy occurring at pH 5.5 or less.¹⁻⁴ When vitamin C is used as a urinary acidifier, 4 to 12 grams per day is recommended,^{2,3} and pH indicator paper should be utilized to regulate the dosage.¹

Nahata, *et al.*⁵ conducted a crossover study on the effect of ascorbic acid on urine pH in ten healthy males. The vitamin was given to each subject at two dosage levels and intervals (four grams divided into four daily doses and six grams divided into five daily doses.) The four grams per day treatment resulted in a mean urine pH lower than either pre-treatment or post-treatment drug-free control periods. Although the results were statistically significant, the greatest effect was that the pH of urine was lowered only by 0.24 units. The six grams per day treatment did not result in a statistically significant change in pH compared in either control period. As a result, the authors concluded that ascorbic acid should not be recommended as a urinary acidifier.

Travis, *et al.*⁶ in an open trial, studied the effect of ascorbic acid as a urinary acidifier in twelve normal subjects. In a dosage of two to eight grams per m² per day, divided into four daily doses, given alone or in combination with methenamine mandelate over a four day period, no consistent decrease of urinary pH was noted. However, when ascorbic

acid was given alone or in combination with methenamine mandelate and administered every four hours around the clock (six times per day) at two to eight grams per m² per day, there was a consistent decrease of urinary pH to below 5.5. The authors concluded that in order to sustain urinary acidification with ascorbic acid, large amounts are needed and it should be administered every four hours around the clock.

Murphy, *et al.*⁷ observed 38 hospitalized patients with chronic urinary infections for three to fifteen months. Ascorbic acid was given orally every four hours in doses varying from three to six grams per day. There was no significant effect in acidifying urine from ascorbic acid alone in patients with infected urine. However, the urine pH was significantly decreased in patients treated with ascorbic acid in combination with methenamine mandelate, and acidity was effectively maintained as well as or better than by the antibacterial therapy alone.

Roy⁸ recently reported a moderate urinary acidification with ascorbic acid (10 grams per day) to a pH of 5.2. He noted that vitamin C is available as ascorbic acid and sodium ascorbate, and for urinary acidification ascorbic acid must be used instead of the sodium salt.

In conclusion, although the value of ascorbic acid as a urinary acidifier has been questioned, it appears to be effective when used in combination with methenamine salts, providing large amounts (four to twelve grams per day) of ascorbic acid are administered at intervals of every four hours around the clock.

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²Anon: Vitamin C and the common cold. *The Medical Letter* 12:106 (Dec. 25) 1970.
³Anon: Methenamine hippurate (Hiprex[®]). *The Medical Letter* 10:59 (July 26) 1968.
⁴Goodman LS and Gilman A: *The Pharmacological Basis of Therapeutics*, 5th edition, New York. MacMillan, 1975, p. 1006.
⁵Nahata MC, *et al*: Effect of ascorbic acid on urine pH in man. *Am J Hosp Pharm* 34:1234-1237 (Nov) 1977.
⁶Travis LB, *et al*: Urinary acidification with ascorbic acid. *J Pediatr* 67:1176-1178 (Dec) 1965.
⁷Murphy FJ, *et al*: Ascorbic acid as a urinary acidifying agent: 2. Its adjunctive role in chronic urinary infection. *J Urol* 94:300-303 (Sept) 1965.
⁸Roy LP: Acidifying effect of ascorbic acid. *N Engl J Med* 297: 1350 (Dec. 15) 1977.

IMPLICATIONS OF MASS MEDICATION WITH ASPIRIN*

Sir William Osler commented, more than a half century ago, that "The desire to take medicine is perhaps the greatest feature which distinguishes man from animals."¹

Indeed, mass medication with drugs is not a new phenomenon under the sun. Civilized man has been engaged in the procedure for centuries. Consider the daily intake of the alkaloid caffeine in tea, coffee, and other beverages. For the most part, but not always, caffeine is benign as ingested in these beverages. Alcoholic beverages have a low benefit/risk ratio yet our per capita consumption of distilled spirits is approximately 2.90 gallons per annum.² A more cogent example of mass medication throughout the world during the last two decades was the introduction of the contraceptive steroids. Although the benefit of failure to conceive is well established, the risks involved have not been delineated completely.

Mass medication with aspirin may be considered another experiment in prophylaxis. However, with aspirin the conditions are different from any of the foregoing cited cases of mass medication. Aspirin has been used regularly for three-quarters of a century throughout the world. In America alone, the daily consumption of the drug in its various dosage forms is approximately 20 tons.³ Among the many people suffering with arthritis (estimated to be 13 million in America), mass medication with comparatively large doses of aspirin is a daily procedure.

RISK OF TOXICITY

In consideration of the anti-platelet aggregation programs under way in America and those that will be started, the benefit/risk ratio must be considered in all of its ramifications. With aspirin, the risk of mass intoxication approaches zero.⁴ The capricious toxicity which includes allergic response or overdose is

minimal with aspirin. The adverse side effects of aspirin are:

1. Gastric discomfort, heartburn, distention, eructation, nausea, and vomiting. These gastrointestinal effects occur mainly with heavy dosage of aspirin and may subside as tolerance to the drug by the gastric mucosa is acquired. This should not cause a problem in the dosage schedule of these studies.

2. Occult micro-bleeding of the gastric mucosa of which the patient is unaware. This occurs in 0.015 percent of the patients ingesting aspirin and involves no serious blood loss.⁵ Micro-bleeding is avoided by administering the aspirin well buffered and with much water.

3. Erosion of the gastric mucosa with frank hemorrhage. This is a very serious problem for which there is no adequate explanation. It may represent a very severe hypersensitivity to aspirin. Aspirin also may be the triggering mechanism that causes massive bleeding from some dormant gastric lesion. Fortunately, such bleeding does not occur frequently. Indeed, when one considers the number of aspirin tablets ingested daily and the number of patients in whom frank gastric hemorrhage occurs capriciously, each may occur in the same individual simultaneously and be entirely unrelated.

Pasteur commented, "When meditating over a disease, I never think of finding a remedy for it, but instead a means of preventing it." Indeed, we have ransacked the entire armamentarium of medical agents for remedies for coronary artery disease and stroke. The rewards have afforded only a limited degree of success. Mass medication with aspirin is the first large-scale attempt to establish, as suggested by the statement of Pasteur, a means of preventing those cardiovascular maladies.

EFFECT OF ASPIRIN ON BLOOD COAGULATION

The effect of aspirin upon the clotting of blood was observed shortly after the turn of the century. The physicians attending the son of the last Czar of

Russia gave the lad aspirin to relieve his painful joints.⁶ Since the boy was suffering from hemophilia the drug aggravated the condition. Rasputin gained favor with the Czar and his family by dismissing the physicians and thus removing the source of aspirin which aggravated the bleeding problem.

In 1950 Dr. L. L. Craven,⁷ a general practitioner of Glendale, California reported that none of his 8,000 patients who had ingested two 300 mg aspirin tablets daily over a period of ten years had suffered from a stroke or a coronary attack. The observation was uncontrolled and involved many factors that could have influenced the result, therefore it was not considered seriously by the profession. However, its significance cannot be overlooked; this observation was in the vanguard of the mass medication with aspirin studies today.

Dr. Harvey Weiss,⁸ hematologist to the Roosevelt Hospital in New York, in 1967 made the observation that the ingestion of aspirin evoked a slight increase in the bleeding time of normal individuals. The observed effect was caused by the diminishing of the aggregation of the platelets. This suggested the possibility of the use of aspirin in the prevention of diseases owing to the clotting of blood in the brain, heart, or other organs.

Other drugs have been shown to do the same thing. For example, the anti-aggregation action on the platelet is elicited by dipyridomole, sulfinpyrazone and a number of nonsteroidal anti-inflammatory agents such as phenylbutazone and indomethacin. Aspirin is as effective but less toxic than any of these drugs. Of special interest is the fact that the effect on the aggregation of platelets is not produced by sodium salicylate. It appears that the acetyl group in aspirin acetylates the platelet and this inhibits its capacity to aggregate. The effect is prolonged and

*The author, John C. Krantz, Jr., Ph.D., is Professor Emeritus, Department of Pharmacology, University of Maryland School of Medicine, Gibson Island, Maryland

likely endures throughout the life of the platelet, four to seven days. It is strange that the effect appears to depend upon the specificity of the acetyl group. It would be interesting to try modifications of the acetyl group on the salicylic acid hydroxyl group such as glycolic acid and aminoacetylated meta and para hydroxy benzoic acids.

**INTRAVASCULAR STIMULI TO
PLATELET AGGREGATION**

The intravascular stimuli which cause platelet aggregation may be antibody complexes, platelet antibodies, bacteria, viruses, endotoxin, and long chain fatty acids. A prime factor in the process is the release of ADP which is responsible for the stickiness of platelets. Several compounds slow the aggregation process. They include nonsteroidal anti-inflammatory compounds such as aspirin and indomethacin. Prostaglandins also are involved.⁹ It is not clear how prostoglandins influence the platelets. They are likely concerned with energy metabolism since aspirin facilitates the reduction of ATP to cyclic AMP which is a positive factor in platelet release.¹⁰

Of special interest is the ability of alternative pathways to initiate platelet aggregation so that hemostasis is not impaired in the normal person.

**PREVENTION OF VASCULAR
ACCIDENTS BY ASPIRIN**

Reports are available from many clinical centers indicating the value of aspirin in the prevention of vascular accidents. For example, in 1974, British investigators¹¹ reported that 600 heart attack patients who had taken one aspirin tablet daily had 25 percent fewer heart attacks than those who had taken a placebo. The evidence at hand suggests that the benefit/risk ratio for mass medication is high. It would appear that individuals who have suffered a heart attack or "little stroke" might reduce their chance of a second episode by the ingestion of aspirin daily.

The wisdom of applying mass medication with aspirin to normal individuals who have no indication of cardiovascular disease but are in an age group where the disease is most frequent is questionable and should be delayed until the outcome of the present studies has been evaluated.

Dr. William Friedenwald, chief of clinical trials of National Heart and Lung Institute, regarding the mass medication with aspirin, stated "Here's a drug that has been used primarily for minor things that may be very effective in treating a major disease."

John C. Krantz, Jr., Ph.D.

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Health Systems Agency (HSA): A Role for the Physician and the County Medical Society

The recommendations of the Executive Committee of the Board of Trustees of the Medical Society of New Jersey, which were spelled out in the last issue of *The Journal* (editorial—The Health Systems Agency, 75:513-514, July 1978) are only a beginning. For emphasis and completeness they deserve repetition:

(a) That all county medical societies within each HSA area should develop close liaison with one another in terms of disseminating information and working together toward influencing HSA activities.

(b) That each county medical society should designate, at least, a staff or board of trustees member whose sole function would be to review and comment to the county society on HSA activities.

(c) That each county medical society, when it believes its local HSA to be acting in conflict with the concept of good health-care delivery, formally should notify, in writing, the Medical Society of New Jersey.

(d) That the Medical Society of New Jersey hire or designate a staff person to collate such reports, study their validity, and recommend appropriate action for consideration by MSNJ's Board of Trustees.

(e) That the Medical Society of New Jersey, where indicated, act as an advocate of the local county society before the State Health Planning Commission in those instances where conflicts have not been resolved at the local level.

These organizational and watchdog functions at the county level, with step-by-step referral for tabulation, evaluation, and appropriate action by the state medical society, represent eminently worthwhile functions *outside* the system. In addition to that approach, however, individual physicians must participate *within the system* at every level. Physicians are "providers" of

services in the bureaucratic taxonomical sense, but they are consumers, taxpayers, and responsible citizens as well. For all of these reasons, we have both a vested interest in the matter and a responsibility to provide some measure of leadership and guidance. The "planners" and "developers" on whom power has been thrust may be so handicapped by the tunnel vision of cost containment that they may flounder and ultimately sink the system. We cannot let that happen and hope to pick up the pieces at some future date.

SEEK POSITIONS

Individual physicians should obtain as many as possible of the 40 to 49 percent of the provider positions on the *Board of Directors* of each HSA. These are elected positions which must be pursued actively. By decree at least one-third of the providers must be responsible for "direct treatment, diagnosis, and care." Could there be a better job description of the physician and a more gracious invitation to join the HSA Board of Directors?

However, the HSA Board of Directors should not be the only HSA goal. Physicians who would consider employment as an alternative to patient care might seek HSA staff appointments. The planners and developers, whose professional training and skills may be allied to medicine, are so distant from patient to professional contact that they need the advice and counsel of a physician.

Berths at higher levels—the *State-wide Health Coordinating Council* (SHCC) and the *State Planning and Developmental Agency* (SPDA)—should be courted. Although the majority of the SHCC appointees must be consumers, the Governor may appoint physicians to that council. The SPDA members also are selected by the Governor, who should be entreated to consider one or more physicians as candidates.

MAKE RECOMMENDATIONS

The kinds of activities and decision making in which the HSAs engage are

such that they will have broad and deep powers. Examples are the appropriateness of services within institutions, the granting of funds by the NIH for use within the HSA area, recommendations concerning certification of health facilities, priorities for construction or conversion of such facilities, and certificate of need reviews.

Specifically, HSAs may judge a pediatric or maternity department to be too unproductive or a cardiac catheterization laboratory to be functioning at too low a case rate to remain in operation and thus recommend closure or merger with another institution. Already they have prevented bed-additions to some New Jersey hospitals. The input into such decision-making procedures surely requires the opinion and knowledge of physicians in the area. Therefore, doctors must be aware of and participate in those procedures—at least by offering recommendations.

PARTICIPATION

Much has been said about PSROs. It is quite clear that failure of physicians to take part in the review system which evaluates professional services is an open invitation to the non-physician professionals and consumers to take over the procedure. Peer review is the best procedure for the medical profession as well as the public, therefore physicians must be active in this program.

Physicians also must play a major role in *active programs* aimed at health problems. This means doctors are essential to infant mortality reduction efforts, to drug and alcohol abuse control and treatment, to detection of disease and to other prevention and control programs. Many such activities can and will be operational without physician participation, but that is not the way it should be.

Each physician may select the area to fit his taste—but each should make such a selection and be actively involved.

RESTRAIN COSTS

The new President of the American Medical Association, Tom E. Nesbitt

M.D., at the assumption of his office made the following statement:

"I am asking the physicians of this nation, on a voluntary basis, to restrain the rate of increase in the fees they charge. If we are properly to participate in cost-containment programs, then we have to say, yes, we are going to restrain the rate of increase in professional fees."

However, professional fees are only part of costs. Physicians must become cost conscious to the point where dollar-saving yet valid alternative techniques are considered regularly. Avoiding unnecessary hospitalization, shortening hospital stays, ordering only essential laboratory tests and x-rays, and the use of preadmission testing, home-care programs, and extended-care facilities are such basic alternatives. It is time to stop practicing "defensive medicine and surgery" and to give careful, thoughtful services within a framework of good fiscal sense.

SUMMARY

The health system of New Jersey reflects the health system of America. It already has been changed remarkably. It will be changed even more.

Changes will occur with or without physician participation. There can be no argument against the thought that the process and the outcome of such change will be in the better interest of the medical profession—if we are a part of the system both collectively and individually. A. Krosnick, M.D.

CMDNJ Notes*

Stanley S. Bergen, Jr., M.D.
President

The current legal status of middle-level health practitioners is a major problem in health care in New Jersey. Forty-nine states now recognize middle-level health practitioners as being an integral part of the health care delivery system and a very important element in the development of equal access to health care within those states.

Repeated federal legislation over the last ten years has called attention to the fact that the broadening of access to adequate health care is dependent upon

the development of a team approach, the development of middle-level health practitioners as part of that team, and the utilization of the skills and expertise of these middle-level practitioners not only to provide access but also to establish a cost-effective method of providing health care for the citizens of this country.

Federal health manpower legislation specifically has encouraged, through awards to medical schools and other appropriate agencies, the development of middle-level health practitioners. The Institute of Medicine has endorsed and projected a positive image of and the need for the expanded use of middle-level health practitioners. Added to this in the positive experience of many other countries in the use of middle-level health practitioners.

Despite this evidence, somehow the State of New Jersey and various agencies and quasi-legal authorities have been able to resist the development and full utilization of these groups in our state. The legal status of nurse practitioners, nurse midwives, and physicians' assistants follows.

According to the Board of Nursing, *nurse practitioners* practice legally under the definition of practical nursing contained within the Nursing Practice Act of 1974. However, the Board of Medical Examiners of New Jersey has raised questions as to the practice of nurse practitioners and recently filed an administrative complaint against the Rutgers Community Health Plan, as well as the individual physicians and nurses employed in the facility, which challenges some of the practices, such as physical examinations, engaged in by the nurses. The Board of Nursing has determined that the nursing practices cited in the complaint clearly are authorized by the Nursing Practice Act. This matter is presently in litigation in the State Supreme Court.

Nurse midwives are licensed by the Board of Medical Examiners, which last April published proposed regulations for principal midwives in the New Jersey Register to govern the practice of certified nurse midwives in the state. Subsequently, however, the board ruled to table any further action on the proposed rule pending a joint meeting between a committee of New Jersey Board of Medical Examiners and the committee of the New Jersey Council of Nurse Midwives. It is the position of nurse midwives, as well as that of the College and other organizations, that the regulations proposed were unduly restrictive

of the practice of nurse midwifery.

Physicians' assistants, at present, have no legal standing in New Jersey. The Medical Practice Act lists categories of health practitioners who may practice under the specific direction of a regularly licensed physician or surgeon, and provides no general delegatory power for physicians. As a result, in order to legalize the practice of physicians' assistants, it is necessary to amend the Medical Practice Act. To do this, Assembly Bill No. 1387, sponsored by Assemblyman George Otowski, and Senate Bill No. 1192, sponsored by Senator Stephan Perski, were introduced into the New Jersey State Legislature.

Physicians' assistants are trained in a baccalaureate program jointly conducted by Rutgers University and CMDNJ. At this time, the only physicians' assistants who can practice in the state are those hired by federal facilities, such as V.A. hospitals, which are not governed by state law.

There have been many false statements made about physicians' assistants and other middle-level health practitioners. It has been claimed that Rutgers University and CMDNJ started their physicians' assistants program without adequate consultation. This is a false statement.

The statement has been made that "the College is now graduating them, let them worry about where they work." I only can say that of our first graduating class of 1977, of the 15 graduates, 14 have very good positions and are contributing to the health and social needs of our country in other states. The 14 who took the national examination, which is sponsored and brought into existence by the AMA, scored over 30 points higher throughout the United States than the rest of the group tested. So, I think it is a tragic loss to the state that these individuals have completed a quality education program, evidenced by their performance on a national examination, and yet are lost to the state.

The physicians' assistants program began in 1971 when the University and the College joined together to sponsor this program and took it to the Medical Society and its House of Delegates for an informal discussion with the then acting dean of the CMDNJ-Rutgers Medical School and the chairman of the CMDNJ board of trustees. It never has passed the House of Delegates of the Medical Society and it has been brought to the floor on at least three separate occasions.

*This month's column is excerpted from my opening remarks at a CMDNJ conference on "Utilization of Middle-Level Health Practitioners" at the Center for Health Affairs, Princeton, on June 1.

But both the University and the College have worked closely with representatives of the Medical Society, and with the board of trustees. We have circulated a questionnaire to all physicians in the state to gain their input, asking their opinion on the use of physicians' assistants, regulations, and so on, to the development of the program. Therefore, any claims that there have not been consultation and communications are entirely false. There has not been approval, that is true, but there certainly has been adequate communication.

There have been multiple studies done over the last 15 years throughout the United States by such prestigious institutions as Duke University, Colorado Medical Center, University of the State of Washington as to the efficacy and appropriateness of the use of middle-level health practitioners. It is a straw man and a false premise to raise the issue that they will weaken the quality of health care. It is false, unfair and inaccurate to raise the issue, "Are they needed?" This issue has been answered adequately in the affirmative. We do not have to reinvent the wheel in New Jersey or prove that New Jersey is different. The difference is not whether middle-level health practitioners are in fact efficient, cost effective, and contributing members of the health-care team but rather whether New Jersey will recognize these factors based on the experience of studies at other institutions and in other states.

I have a personal uneasy feeling that the real issues are economics and status rather than the contribution to the health care system or the delivery of health care to the people who are systematically excluded from access to health care at this time. Unless we can get beyond the economic and status issues, then we will continue to have false issues brought before us. There is no doubt that this is the real problem and that it should be faced squarely by the people of New Jersey, not by vested interest groups.

I think it is important to realize that the use of middle-level health practitioners actually is beneficial to the physicians in that it frees them to use their talents as they were educated to use them, and to use them in a more productive manner than by being shackled with many of the responsibilities and duties that easily and adequately can be assumed by other professionals.

Report from the Foundation

Daniel J. O'Regan, M.D.
Medical Director

The officers of the Foundation for 1978-79 are as follows:

President

James A. Rogers, M.D.

President-Elect

Jack E. Shangold, M.D.

First Vice-President

George L. Benz, M.D.

Second Vice-President

Edward Josell, M.D.

Secretary

Howard Zeidman, M.D.

Treasurer

John R. O'Brien, M.D.

The approval of continuing financial support of NJFHCE by both our parent bodies (MSNJ and NJAOPS) was most appreciated. The House of Delegates of both organizations passed resolutions in May which assure our continuing efforts on your behalf. Our Federal funding as the statewide Support Center for New Jersey PSROs ended on March 31.

Also appreciated were the kind remarks by Charles S. Krueger, M.D., in his inaugural address as President of MSNJ on May 7. Dr. Krosnick's editorial in the June issue of the Journal (75:451) states that: "Dr. Krueger is very proud of his service to the New Jersey Foundation for Health Care Evaluation as a founder, board member, and former Treasurer." The Foundation is also proud to have had Dr. Krueger's participation from the beginning. Dr. Rogers is a Past President of MSNJ, as was Dr. William J. D'Elia, who led NJFHCE in 1975-76. These names reflect the men of vision and leadership who established this Foundation and continue to guide it.

Academy of Medicine Awards

On Wednesday, May 10, at the Academy of Medicine of New Jersey Awards Dinner, the Edward J. Ill Award for extraordinary service to the medical profession was presented to Victor Parsonnet, M.D., of Millburn. Doctor Parsonnet, a diplomate of the American Board of Surgery, is director of surgery at Newark Beth Israel Medical Center and clinical professor of surgery at the New Jersey Medical School, CMDNJ. He is past-president of the Essex County

Heart Association and of the Academy of Medicine of New Jersey. He also was chairman of the Cardiovascular Surgery Committee of the New Jersey Regional Medical Program. He authored the first report which recommended numerical regulation of open heart surgery units in the State. This has served as a model on the national level. Dr. Parsonnet presently is Governor of the New Jersey Chapter of the American College of Cardiology, Chairman of the Medical Advisory Committee, a member of the board of trustees of the Regional Health Planning Council in Newark, and is President-Elect of the New Jersey Chapter of the American College of Surgeons. He was recipient in 1953 of the first Annual Harrison S. Martland Award for his work in the anatomy of the veins of the human heart.

Named as the "citizen of New Jersey who has contributed in an outstanding fashion to the solution of health and health care problems in the state" was Gustave O. Lienhard, who is chairman of the board of trustees of The Robert Wood Johnson Foundation. A former president of Johnson and Johnson worldwide, Mr. Lienhard presently is a trustee and member of the executive committee of the Foundation of the College of Medicine and Dentistry of New Jersey.

Dr. Bernstein Named Director of Crossroads Health Plan

Arthur Bernstein, M.D., our well-known Secretary of the Board of Trustees, as well as of the State Society, has retired from private practice and has accepted appointment as Medical Director of the Crossroads Health Plan and its affiliated Essex County Health Organization. Crossroads is the new HMO serving Essex County and is an Individual Practice Association (IPA) in which physicians' services are provided from a pool, allowing the enrollees to choose their own participating doctor. Under Doctor Bernstein's direction Crossroads will launch a health education program centering on preventive medicine. Doctor Bernstein is senior attending in medicine at both Newark Beth Israel Hospital and St. Barnabas Medical Center, and attending cardiologist at Newark Children's Hospital. He is clinical professor of medicine at New Jersey Medical School, CMDNJ.

Physicians Seeking Location in New Jersey

The following physicians have written to the Executive Office of MSNJ seeking information on possible opportunities for practice in New Jersey. The information listed below has been supplied by the physician. If you are interested in any further information concerning these physicians, we suggest you make inquiries directly to them.

ADOLESCENT MEDICINE—Robert S. Smith, M.D., 39 Fairlane Drive, Wethersfield, CT 06109. Medical College of Virginia 1969. Special interest, adolescent psychiatry. Board eligible, pediatrics and psychiatry. Group, solo. Available July 1979.

AEROSPACE MEDICINE—Laurence H. Blackburn, Jr., M.D., 56 Woodcrest Lane, Doylestown, Pennsylvania 18901. Johns Hopkins University 1955. Board certified. Industrial, group, or administrative. Available August 1978.

ANESTHESIOLOGY—Arundev Dahyabhai Desai, M.D., 7-29 Hegman Ave., Apt. 17-C, Brooklyn, NY 11212. B.J. Medical College (India). Board eligible. Group, partnership, solo, salaried. Available.

Mahendra N. Sampat, M.D., Nassau County Medical Center, 2201 Hempstead Turnpike, East Meadow, New York 11554. Calcutta (India) 1969. Board eligible. Group, partnership, institution. Available.

Yi Shien Lin, M.D., 636 Brooklyn Avenue, Apt. 14-C, Brooklyn, New York 11203. Koahsiung (Taiwan) 1968. Board eligible. Group or partnership. Available.

Cesar A. Souza, M.D., 331 Theatre Drive, 1C14, Johnstown, PA 15904. Montevideo (South America) 1967. Board eligible. Group or solo. Available.

Alan D. Weinstock, M.D., 320 Ocean Parkway, Brooklyn, New York 11218. Albert Einstein 1974. Board eligible. Group, partnership, or institution. Available.

Anselma L. Canlas, M.D., 385 Wildrose Avenue, Bergenfield 07621. Santo Tomas (Philippines) 1969. Board certified. Group or partnership. Available January 1979.

CARDIOVASCULAR DISEASES—Sae Kirl Kim, M.D., 8-C Borden Apartments, Third Avenue, Long Branch 07740. Chonnam University (Korea) 1967. Subspecialty, internal medicine. Board eligible (IM). Group, partnership. Available.

W. Bruce Fye, M.D., 307 Overbrook Road, Baltimore, Maryland 21212. Johns Hopkins 1972. Subspecialty, internal medicine. Board certified (IM). Group or institution. Available.

Anil G. Kothari, M.D., 9500 Euclid Avenue, Cleveland, Ohio 44106. Topiwala Medical School (India) 1972. Subspecialty, internal medicine. Board certified (IM). Group, partnership, institution. Available.

DERMATOLOGY—Robert W. Gurney, M.D., 333 East Ontario Street, #4309, Chicago, Illinois 60611. Georgetown 1974. Board eligible. Group or partnership. Available.

EMERGENCY MEDICINE—Raymond P. Limansky, M.D., 950 49th Street, Apt. 4-F, Brooklyn, New York 11219. University of Barcelona 1974. Subspecialty, general practice. Solo or emergency room. Available.

Karshandas N. Kacha, M.D., 61 Bross Place, Apt. 15-A, Irvington 07111. B.J. Medical College (India) 1969. Subspecialty, family practice. Group, emergency room. Available.

ENDOCRINOLOGY—Jamshid Alizadeh, M.D., 1427 East Willow Lake Drive, NE, Atlanta, Georgia 30329. Tehran Medical School (Iran) 1968. Subspecialty, internal medicine. Board certified (IM). Group, public or school health, institution. Available September 1978.

Frederick E. Lewis, M.D., 445 East 68th Street, Apt. 4-B, New York, New York 10021. Albany Medical College 1971. Subspecialty, internal medicine. Board certified (IM). Group, partnership, or solo. Available.

FAMILY PRACTICE—Gwendolyn D. Williams, M.D., 557 W. 141st Street, New York, New York 10031. University of Zurich 1963. Subspecialty, pathology. Board eligible (path.). Group or public health. Available.

Lawrence I. Weissman, M.D., 10 Salem Park, Elizabeth, New Jersey 07208. New York Medical College 1975. Board eligible. Group or partnership. Available.

Thomas P. Harakal, M.D., 202 Laura Drive, Danville, Pennsylvania 17821. Temple 1975. Board eligible. Group, partnership, research. Available.

Julio E. Pardave, M.D., 2650 Selwyn Avenue, Apt. 20-D, Bronx, New York 10457. San Marcos (Peru) 1973. Subspecialty, pediatrics. Board eligible, pediatrics. Group, partnership, public health. Available.

Janet Crane Vassar, M.D., 2029 Nuuanu Avenue, Honolulu, Hawaii 96817. Medical College of Pennsylvania 1977. Partnership, school health, solo. Available.

Ramzy Nasr Nabih, M.D., 126 Minges Circle, Battle Creek, Michigan 49015. Cairo (Egypt) 1947. Board eligible. Group or partnership. Available.

GASTROENTEROLOGY—Robert A. Sable, M.D., 2500 F Johnson Avenue, Apt. 15-A, Bronx, New York 10463. Einstein College of Medicine 1973. Subspecialty, internal medicine. Board certified (IM). Group, partnership. Available.

Philip J. Di Giacomo, Jr., M.D., 2108 B Crosby Street, Philadelphia, Pennsylvania 19112. Jefferson 1972. Subspecialty, internal medicine. Board certified (IM). Group, partnership. Available July 1979.

Drew P. Ronnermann, M.D., 275 Bryn Mawr Avenue, Apt. K-43, Bryn Mawr, PA 19010. NYU 1974. Subspecialty, internal medicine. Board eligible. Board certified (IM). Group or partnership. Available July 1979.

GYNECOLOGY—S. Stanley Barr, M.D., 255 South 17th Street, Philadelphia, Pennsylvania 19103. Hahnemann 1933. Board certified (obstetrics & gynecology). Group or partnership. Available.

HEMATOLOGY—Jean Bello Belasco,

M.D., 34 Fidelity Courts, Carrboro, North Carolina 27510. Temple University 1973. Subspecialty, pediatrics. Board eligible (pediatrics). Institution, group, or research. Available.

INTERNAL MEDICINE—Stephen Winograd, M.D., 208 Walnut Street. Montclair 07042. NYU 1972. Subspecialty, gastroenterology. Board certified. Group, partnership, solo. Available.

Martin R. Mersky, M.D., 1722B Ferndale Avenue, Abington, Pennsylvania 19001. Jefferson 1975. Board eligible. Group, partnership, solo, institution, industrial, academic, or public health. Available August 1978.

Sang Hee Park, M.D., 102 Livermore Street, Boston, Massachusetts 02126. Catholic Medical College (Korea). Subspecialty, nephrology. Board certified (IM). Group or partnership. Available.

Barry J. Buls, M.D., 710 East Seventh Street, Brooklyn, New York 11218. New York Medical College 1975. Board eligible. Group, partnership, solo. Available.

Jameel Katmeh, M.D., Deborah Heart and Lung Center, Browns Mills 08015. Damascus (Syria) 1972. Subspecialty, cardiovascular diseases. Board eligible (cardiovascular diseases). Group or partnership. Available.

Dunthur M. Puttaswamy, M.D., 10A Southgate Apts., 272 Ward Avenue, Bordentown 08505. University Medical College, Mysore (India) 1954. Board eligible. Group, solo, or institution. Available.

Alexander D. Shimanovsky, M.D., 221 Morris Avenue, Summit 07901. 1st Medical Institute (Russia) 1971. Board eligible. Group or partnership. Available.

Drew Paul Ronnermann, M.D., 275 Bryn Mawr Avenue, Apt. K-43, Bryn Mawr, Pennsylvania 19010. New York Medical College 1974. Subspecialty, gastroenterology. Board certified. Group or partnership. Available July 1979.

Marta Stekelman, M.D., P.O. Box 900, Hightstown 08520. Bs. As. Medical School 1959. Subspecialty, gastroenterology. Board eligible. Group, partnership, solo, research, hospital-based. Available.

Renuka Kumar, M.D., 8 Valley Park South, Bethlehem, PA 18018. University of Delhi 1970. Board eligible. Group, partnership, hospital-based, solo. Available.

Edward B. Ruby, M.D., 9928 Sandy Road, Philadelphia, PA 19115. Jefferson, 1971. Subspecialty, endocrinology. Board certified (IM and endocrinology). Group or partnership. Available.

David C. Sobel, M.D., 181 Long Hill Road, Apt. 4-8, Little Falls 07424. SUNY (Downstate) 1976. Board eligible. Partnership or solo. Available July 1979.

Kim King Chan, M.D., 425 Goler House Apts., Rochester, New York 14620. Santo Tomas (Philippines). Board eligible. Group, solo, associate. Available.

NEPHROLOGY—Prakash Ananthanarayan, M.D., 1590 Anderson Avenue, Apt. 16-D, Fort Lee 07024. Calicut (India) 1970. Subspecialty, internal medicine. Board certified (IM). Group, partnership, solo. Available.

- Joseph Jyh Chung Lee, M.D., 5131 Wissoming Road, Washington, DC 20016. National Taiwan University 1971. Subspecialty, internal medicine. Board certified (IM). Group, partnership, institution. Available.
- Allan A. Shook, M.D., 32 East Gravers Lane, Philadelphia, Pennsylvania 19118. NYU, Syracuse 1973. Board eligible. Group or partnership. Available.
- NEUROLOGY**—Riaz A. Janjua, M.D., 153 West 11th Street, New York, NY 10011. King Edward, Lahore (Pakistan) 1972. Board eligible. Group, partnership, solo, research, public health, school health. Available.
- Alan J. Tuchman, M.D., 828 Talbott Road, Wright-Patterson AFB, Ohio 45433. University of Cincinnati 1972. Board eligible. Group, institution, partnership, industrial, public health, administrative. Available.
- Jan J. Golnick, M.D., 4 Park Avenue, Apt. 8E, New York, NY 10016. Silesian School of Medicine (Poland) 1967. Board eligible. Group, partnership, institution. Available.
- OBSTETRICS/GYNECOLOGY**—William L. Schneiderman, M.D., 71 Woodside Circle, Lakeridge, Torrington, CT 06790. NYU 1974. Board eligible. Group or partnership. Available.
- Iraj Nakhjavan, M.D., 122-1/2 Center Street, Ridgway, PA 15853. Tehran (Iran) 1961. Subspecialty, family practice. Solo, partnership, group. Available.
- Kamrul Hasan, M.D., 18220 Lorain Avenue, Apt. 66, Cleveland, OH 44111. Dow Medical College (Pakistan) 1972. Board eligible. Group, research, partnership. Available.
- Saud A. Tarawneh, M.D., 2212 Foxbourne Road, Toledo, OH 43614. Damascus (Syria) 1967. Board eligible. Solo, partnership, group. Available.
- Susane L. Friedlander, M.D., 305 East 24th Street, Apt. 10-C, New York, NY 10010. NYU 1974. Board eligible. Group, partnership. Available September 1978.
- Kapila M. Patel, M.D., 609 Mix Avenue, Apt. B-1, Hamden, Connecticut 06514. Baroda (India) 1968. Board eligible. Group. Available September 1978.
- Richard A. Peters, M.D., 3404 Glorus Place, Wheaton, Maryland 20902. NYU 1973. Board eligible. Group, partnership, institution, administrative. Available.
- Yousef S. Banoud, M.D., 162 Sunset Avenue, Farmingdale, New York 11735. Ain-Shams University (Egypt) 1965. Board eligible. Partnership, solo, group. Available.
- OCCUPATIONAL MEDICINE**—Lawrence Z. Shultzaberger, M.D., 10 Pinecrest Drive, Cortland, NY 13045. Hahnemann 1951. Industrial, school health, administrative. Available.
- OPHTHALMOLOGY**—Edward Y. Shen, M.D., 636 Brooklyn Avenue, Brooklyn, NY 11203. Kaohsiung (Taiwan) 1966. Board eligible. Any type practice. Available.
- Michael J. Newton, M.D., 1370 Veteran Avenue, Apt. 119, Los Angeles CA 90024. Tufts 1971. Board eligible. Partnership, group, solo, research. Available.
- Javad N. Sani, M.D., 2301 6th Street, South, Apt. 3, Arlington, VA 22204. Tehran (Iran) 1972. Board eligible. Research, group, partnership. Available.
- Nissim Joseph, M.D., 110 Babcock St., Apt. 41, Brookline, MA 02146. Tel-Aviv University (Israel) 1968. Board eligible. Group, research, partnership, solo. Available.
- Peter J. Cetta, M.D., 7653 Normandie Boulevard, Apt. C-33, Middleburg Heights, Ohio 44130. CMDNJ 1975. Board eligible. Group, partnership, solo. Available July 1979.
- PATHOLOGY**—Vidya Deshpande, M.D., 11433 Maridosa Trail, Apt. B, Florissant, Missouri 63033. B.J. Medical College (India) 1970. Board certified. Special interest, anatomic and clinical pathology. Group. Available July 1978.
- Solomon Rendler, M.D., 1482 E. 8th Street, Brooklyn, NY 11230. Wisconsin 1974. Special interest, clinical pathology. Board certified. Institution, academic, group. Available.
- Balshik Min, M.D., 141 Old Short Hills Road, Apt. 11, West Orange 07052. Seoul University (Korea) 1966. Board eligible. Institution, group, partnership. Available.
- Sangeeta A. Shah, M.D., 129 Brook Haven, Deridder, LA 70634. Grant Medical School (India) 1970. Board certified. Subspecialty, clinical pathology. Partnership, solo, group, institution, industrial. Available.
- PEDIATRICS**—C. B. Rao, M.D., 1825 Parkside Drive, Apt. I-2, Parkridge, Illinois 60068. Guftur Medical College (India) 1966. Board eligible. Partnership, group, solo. Available July 1978.
- Andrew Stachewitsch, M.D., 96 Easton Avenue, Montreal West H4X 1L2, Quebec, Canada. Freiburg (Germany) 1955. Subspecialty, hematology. Board eligible (both). Solo, group, institution. Available.
- Eric J. Flug, M.D., 813 Westwood Drive, Clayton, MO 63105. St. Louis University 1975. Board eligible. Partnership, group, institution, emergency room. Available.
- Natalio Schwartz, M.D., 7660 SW 82nd Street, Apt. H-110, Miami, FL 33143. University of Chile 1972. Board certified. Institution, group, partnership. Available August 1978.
- Mahrugh D. Bamji, M.D., 3091 Edwin Avenue, Apt. 4A, Fort Lee 07024. Grant Medical College (India) 1970. Board eligible. Institution, group. Available.
- Shahina Qureshi, M.D., 200 Carman Avenue, Apt. 4-J, East Meadow, NY 11554. Dow (Pakistan) 1972. Subspecialty, hematology/oncology. Group, partnership. Available.
- Anita C. Dy, M.D., 1947 85th Street, Brooklyn, NY 11214. University of the East (Philippines) 1967. Board certified. Solo, partnership, group. Available.
- Burton Banner, M.D., 525 Ocean Parkway, Apt. 2A, Brooklyn, NY 11218. Downstate Medical Center 1974. Board eligible. Partnership, group. Available.
- Paul S. Spivack, M.D., 7095 Santa Paula Circle, Buena Park, CA 90620. SUNY, Downstate 1975. Board eligible. Group, institution, partnership. Available.
- Irving Zultan, M.D., 1935-3C Eastchester Road, Bronx, NY 10461. Albert Einstein 1974. Board eligible. Partnership, group, research. Available.
- PHYSICAL MEDICINE/ REHABILITATION**—Vidya J. Rao, M.D., 100 Livingston Avenue, Edison 08817. Sarojini-Naidu Medical College (India) 1971. Board eligible. Full-time job in hospital as physiatrist. Available.
- Kyung Dok Yoon, M.D., 80-15 41st Avenue, Apt. 342, Elmhurst, NY 11373. Yonsei (Korea) 1971. Board Eligible. Institution, group, partnership. Available.
- William Green, M.D., 1935-6C Eastchester Road, Bronx, NY 10461. Guadalajara 1972. Board eligible. Group, solo. Available.
- PSYCHIATRY, ADOLESCENT**—Robert S. Smith, M.D., 39 Fairlane Drive, Wethersfield, CT 06109. Medical College of Virginia 1969. Special interest, adolescent medicine. Board eligible, pediatrics and psychiatry. Group, solo. Available July 1979.
- RADIOLOGY**—Sudarshan K. Singla, M.D., 175 Ardsley Loop, Apt. 18H, Brooklyn, NY 11239. Amritsar (India) 1969. Special interest, diagnostic radiology. Board eligible, diagnostic radiology. Partnership, group. Available.
- Kundan L. Gupta, M.D., 24474 Haskell, Apt. 94, Taylor, MI 48180. Amritsar (India) 1969. Board eligible. Special interest, diagnostic radiology. Solo, group. Available.
- SURGERY, CARDIOVASCULAR**—Samuel C. Balderman, M.D., 5623 N. Bernard, Chicago, IL 60645. University of Illinois 1972. Subspecialty, thoracic surgery. Board certified (general surgery). Research, institution, group. Available.
- SURGERY, GENERAL**—Peter R. Douglas, M.D., Two Rosewood Lane, Essex Junction, Vermont 05452. SUNY (Downstate) 1971. Board eligible. Any type practice. Available July 1978.
- Alessandro Ferrero, M.D., 1915 Laird Drive, Salt Lake City, Utah 84108. Università di Torino (Italy) 1967. Special interest in thoracic and cardiovascular surgery. Board certified. Group or partnership. Available July 1978.
- Shshilkumar R. Samant, M.D., Texas Heart Institute, P.O. Box 20269, Houston, TX 77025. Seth G. S. Medical College (India) 1970. Special interest, thoracic surgery. Board eligible. Any type practice. Available.
- Simon B. Santos, M.D., 8720 Chestnut Circle, Apt. 4, Kansas City, MO 64131. Santo Domingo (Dominican Republic) 1972. Board eligible. Partnership, group. Available.
- Rao V. Daluvoy, M.D., 950 49th Street, Apt. 9A, Brooklyn, NY 11219. Guntur (India) 1965. Board eligible. Group, partnership, solo. Available.
- Anthony R. Bescher, 51 Parkview Court, Lancaster, NY 14086. Jefferson 1971. Board eligible. Group, partnership. Available.

Fitzclarence Griffith, M.D., 17310 Whitcomb, Detroit MI 48235. Univ. of West Indies (Jamaica) 1971. Subspecialty, general practice. Board eligible. Partnership, group, public health. Available.

Frank P. Gudicello, M.D., 331B Third Avenue, Long Branch 07740. University of Bologna (Italy) 1974. Board eligible. Solo, partnership, group. Available.

Carlos A. Medina, M.D., 787 Chambord Circle, Marion, OH 43302. National University (Bogota) 1971. Board eligible. Subspecialty, emergency medicine. Group, emergency room. Available.

Kyum Tak Kim, M.D., 501 Sixth Street, Apt. 10C, Brooklyn, NY 11215. Seoul (Korea) 1968. Board eligible. Partnership, solo, group. Available.

Amelito P. Canlas, M.D., 385 Wildrose Avenue, Bergenfield 07621. University of Santo Tomas (Philippines) 1971. Board eligible. Group, partnership, solo. Available.

SURGERY, ORTHOPEDIC—Michael G.

Dolin, M.D., 100 Avenue P, Brooklyn, NY 11204. New York Medical College 1970. Board eligible. Group, partnership. Available September 1978.

Mohamed Khalafalla Nour, M.D., 237 Fairhaven Boulevard, Woodbury, NY 11797. Cairo (Egypt) 1959. Board eligible. Solo. Available.

Robert B. West, M.D., 8 Louise Lane, Tenaflly 07670. Columbia 1973. Board eligible. Group, partnership. Available.

SURGERY, THORACIC—Imad F. Tabry, M.D., 1200 4th Street, NW, Rochester, MN 55901. French School of Medicine (Lebanon) 1970. Board eligible. Board certified (general surgery). Research, partnership, group. Available.

SURGERY, UROLOGICAL—Jorge A. Saborio, M.D., 30-43 69th Street, Woodside, NY 11377. National, Leon (Nicaragua) 1970. Board eligible. Group, partnership, solo. Available.

Marvin L. Stein, M.D., 3801 Hudson Man-

or Terrace, Apt. 5L, Riverdale, NY 10463. Board eligible. Group, partnership, solo. Available.

Paul F. Low, M.D., 128-4 Kirkbride Road, Voorhees 08043. CMDNJ 1973. Board eligible. Partnership, group, solo. Available.

Larry E. Goldstein, M.D., 552 Rossmore Road, Richmond, VA 23225. Jefferson 1973. Board eligible. Partnership, solo, group. Available.

Joel S. Cohen, M.D., 3880 La Jolla Village Drive, La Jolla, CA 92037. Guadalajara 1972. Board eligible. Partnership, group, solo. Available.

Satish A. Dhagat, M.D., 1 Liberty Street, Apt. C-12, Little Ferry 07643. B.J. Medical College (India) 1966. Board eligible. Group, partnership. Available.

Gerald A. Goldman, M.D., 2913 Willowood Drive, Erie, Pennsylvania. Guadalajara 1972. Board eligible. Association leading to partnership. Available July 1979.

LETTERS TO THE JOURNAL

Dr. Gordon Honored

May 18, 1978

Dear Dr. Krosnick:

As the Civil Air Surgeon of Israel, I attended the Aerospace Medical Association meeting in New Orleans, May 7 to 12.

As a member of the New Jersey Medical Society for almost 40 years, I thought you might mention in *The Journal* that I gave a paper on poisoning in spray pilots, was elected a Fellow of the Society, and also elected a Vice-President.

Since I was floating on air, I wanted my old friends from Camden County and the state to share it with me. If there is no such column, please forget it, but do pass the information on to my friend, Dr. Arthur Bernstein.

I signed another contract for two years, so come visit the Holy Land.

(signed) Dr. Milton Gordon
Civil Air Surgeon, State of Israel

Note: Correspondence may be addressed to Dr. Gordon at 16 Sokolov Street, Apartment 11, Jerusalem, Israel.

Editorial Policy

May 29, 1978

Dear Editor:

As a fellow editor, an amateur journalist, and a liberal-minded person, I must applaud your editorial on "Editorial Policy" in the April issue of *The Journal*.

You have stated the principles in clear and unequivocal terms, which too many of our colleagues are unable to recognize because of the narrowness of their vision.

Keep up the good work!

(signed) Bertram Levinstone, M.D.

Insect Sting Kit

July 7, 1978

Gentlemen:

In preparation for a September meeting of the National Institute of Allergy and Infectious Diseases to consider the feasibility and advisability of making the insect sting kit available to certain trained categories of medical and lay persons, without a specific prescription

by a physician, I would be interested in receiving information and comments by the readers of this journal on the following questions:

1. Have you any knowledge of a fatal reaction to an insect sting or drug or food? If so, I would appreciate as much detail as possible, including information concerning the time interval between contact with the offending agent and death.
2. If you know of such a fatality or fatalities, in your estimation, would an immediate subcutaneous injection on the scene of a premeasured dose of epinephrine 1:1000 (0.3cc to 1.5 for adult, 0.2 to 0.3 cc for children) have afforded a different outcome?
3. Have you any knowledge of adverse effects of subcutaneous injections of epinephrine 1:1000 in the above dosages? If so, again I would appreciate as much detail as possible.

We would certainly appreciate any information you can supply.

(signed) Claude A. Frazier, M.D.

Note: Please reply to: Doctors Park, Bldg. #4, Asheville, NC 28801.

Carrier Foundation Symposium on Aging

The 18th annual symposium of the Carrier Foundation, entitled "Aging: Ourselves Tomorrow," will be held on September 27 at the facility in Belle Mead. In addition to a panel discussion, topics to be presented include "Geriatrician's Approach to Dementia and Pseudo Dementia," "Better Living Through Chemistry," "Aging and Sexuality," "Psychotherapy of the Elderly," and "Social and Cultural Context of Aging." There is no registration charge but a \$3 fee is payable at the time of the meeting and a donation will be accepted for the luncheon. Seven credit hours will be awarded in Category I of the AMA Physician's Recognition Award. For additional information please communicate with Robert S. Garber, M.D., President, Carrier Foundation, Belle Meade 08502—(201) 874-4000.

Graduate Course in Obstetrics and Gynecology

The Saint Barnabas Medical Center in Livingston will present its 18th annual graduate course—"A Clinical and Histopathologic Overview of Obstetrics and Gynecology"—October 3 to 7 at the Waldorf Astoria in New York. Purpose of the course is to orient the obstetrician and gynecologist with an in-depth survey of the female genital tract. Emphasis will be on clinical correlations and various histopathologic entities encountered in these specialties. Gross and microscopic materials will be studied and correlated with the clinical picture of disease entities. Fifty cognates will be given by the American College of Obstetricians and Gynecologists and forty credit hours will be awarded in Category I of the AMA Physician's Recognition Award. The fee is \$450 which includes booklets and slides. A non-refundable deposit of \$25 is payable with application for registration. The balance is due before October 1st.

Special consideration will be given to Senior Residents. For registration and hotel information please communicate with James L. Breen, M.D., Director, Department of Obstetrics and Gynecology, Saint Barnabas Medical Center, Livingston, New Jersey 07039.

Symposium on Infant and Child Feeding

From October 15 to 19 at Michigan State University in East Lansing, the Nutrition Foundation will present an international symposium on infant and child feeding. Recognized authorities in this field will review current information on nutrient requirements for growth and development and will examine the relationship of nutrition to behavioral patterns and socioeconomic change. Other matters to be discussed are the historical development of infant and child feeding, current practices in developing and industrialized nations, the physiology of lactation, weaning foods, and infant formulas. For further information please communicate with Ann Tsiminakis, Conference Coordinator, The Kellogg Center, Room 23, Michigan State University, East Lansing, Michigan 48824.

Course in Gynecologic Endoscopy

Under the sponsorship of the New Jersey Fertility Foundation, a course in Gynecologic Endoscopy will be held October 19 and 20 in Roselle Park. Thirteen credit hours will be awarded in Category I of the AMA Physician's Recognition Award and 20 cognates by the American College of Obstetricians and Gynecologists. For information please communicate with G. E. Laubach, M.D., 14 East Westfield Avenue, Roselle Park 07204.

Symposium on Geriatric Medicine

A symposium on geriatric medicine for physicians and other health pro-

fessionals will be held on October 20 and 21 at the Hunt Valley Inn in Baltimore. Sponsored by the American Geriatrics Society and Franklin Square Hospital, the conference will emphasize practical information to enhance the quality of medical care for the elderly. The program is acceptable for 14 credit hours in Category I of the AMA Physician's Recognition Award. For additional information, please communicate with William Reichel, M.D., Health and Education Council, 7201 Rossville Boulevard, Baltimore 21237—(301) 686-3610.

Interstate Scientific Assembly

From October 23 to 26, at the Washington Hilton in Washington, D.C., the Interstate Postgraduate Medical Association, a teaching service directed principally to the interests of family and other primary care physicians will present an assembly consisting of lectures, informal group discussions, closed-circuit TV and medical motion pictures. The program has been planned cooperatively with the Academy of Family Practice (District of Columbia chapter), the University of Maryland, Howard University, and Georgetown University. Topics include rheumatology, gastroenterology, pediatrics, infectious diseases, cardiology, and an update on current trends and technology.

Twenty-four prescribed hours will be credited for members of the Academy of Family Physicians, and credit also will be given in Category I of the AMA Physician's Recognition Award. Advance registration fee is \$75; the cost is \$100 if paid at the time of the meeting. For additional information and hotel registration forms please communicate with Alton Ochsner, M.D., Program Chairman, Interstate Postgraduate Medical Association, P.O. Box 1109, Madison, Wisconsin 53701.

CME CALENDAR

This listing is compiled through the cooperation of the Committee on Medical Education of the Medical Society of New Jersey, the Academy of Medicine of New Jersey, the New Jersey Chapter of the American Academy of Family Physicians, and the Office of Continuing Medical Education of the College of Medicine and Dentistry of New Jersey. For information on accreditation, please contact the sponsoring organization(s), indicated by italics—last line of each item.

Aug.

- 16 Grand Rounds and Case Presentations**
- 23** 2-4 p.m.—Rotating between Martland,
- 30** Newark Beth Israel, St. Michael's, St. Joseph's Hospitals and Jersey City Medical Center
(CMDNJ and AMNJ)
- 17 Grand Rounds and Case Presentations**
- 24** 4-5 p.m.—Martland Hospital, Newark
- 31** *(CMDNJ and AMNJ)*
- 17 Solo Practitioner in Psychiatry**
12 noon-1 p.m.—Carrier Foundation Belle Mead
(Carrier Foundation)
- 21 Basic Life Support Certification Course**
12 noon-1 p.m.—Walson Army Hospital, Fort Dix
(Walson Army Hospital and AMNJ)
- 25 Diagnostic and Therapeutic Problems in Orthopedics**
7:30-9 a.m.—Alexian Brothers Hospital Elizabeth
(Alexian Brothers Hospital)

Sept.

- 1 Diagnostic and Therapeutic Problems in**
- 8 Orthopedics**
- 22** 7:30-9 a.m.—Alexian Brothers Hospital, Elizabeth
(Alexian Brothers Hospital)
- 6 Geriatrics-Concepts and Differences**
- 20 Geriatrics-Syndromes Outpatient Rx**
1-3 p.m.—Ancora Psychiatric Hospital Hammonton
(Ancora Psychiatric Hospital and AMNJ)
- 6 Grand Rounds and Case Presentations**
- 13** 2-4 p.m.—Rotating between Martland,
- 20** Newark Beth Israel, St. Michael's, St.
- 27** Joseph's Hospitals and Jersey City Medical Center
(CMDNJ and AMNJ)
- 6 Continuing Education in Psychiatry**
1-3 p.m.—Bergen Pines County Hospital, Paramus
(Bergen Pines Hospital and AMNJ)
- 7-4th Memorial Ignatz Semmelweis**
- 11 Seminar**
Playboy Club, Great Gorge, New Jersey
(New Jersey Medical School, AMNJ, and AAFP)
- 7 Grand Rounds and Case Presentations**
- 14** 4-5 p.m.—Martland Hospital, Newark

- 21** *(CMDNJ and AMNJ)*
- 28**
- 7 Psychiatric Lecture Series**
- 14** 11 a.m.-12 noon—Greystone Park Psychiatric Hospital
- 21**
- 28** *(Greystone Park Psychiatric Hospital and AMNJ)*
- 8 Allergy**
8:30-9:30 a.m.—United Hospitals of Newark
(United Hospitals of Newark and AMNJ)
- 12 Allergy**
- 19 Proper Use of Antibiotics**
- 26 Dermatology**
11 a.m.-12 noon—Greystone Park Psychiatric Hospital
(Greystone Park Psychiatric Hospital and AMNJ)
- 12 Surgical Lecture—Motor Disorders of the Esophagus**
5-6 p.m.—Rutgers Medical School, Piscataway
(CMDNJ and AMNJ)
- 13 Burns, Current Treatment**
- 20 Congestive Heart Failure**
- 27 Emergency Care**
10:30-12 noon—St. Mary's Hospital, Passaic
(St. Mary's Hospital and AMNJ)
- 13 Diagnosis and Treatment of Depression**
- 20 C.P.R. for Physicians**
- 27 Radiology-Pathology Conference**
11:30 a.m.-1:30 p.m.—Rahway Hospital
(Rahway Hospital and AAFP)
- 13 Chronic Obstruction Pulmonary Disorders**
- 20 Arthritis**
- 27 Hypertension**
1-3 p.m.—Christ Hospital, Jersey City
(Christ Hospital and AMNJ)
- 13 Medical Aspects of Psychosomatic Illness—Part I**
- 27 Part II**
3:15-4:15 p.m.—Fair Oaks Hospital, Summit
(Fair Oaks Hospital and AMNJ)
- 13 Cardiology Conferences**
4-6 p.m.—Rutgers Medical School, Piscataway
(CMDNJ, Somerset County Heart Association and AMNJ)
- 14 Prophylactic Use of Antibiotics**
8-9 p.m.—Mount Holly Center, 62 Richmond Ave., Mount Holly
(Burlington County Medical Society, AMNJ and AAFP)
- 14 Case Presentations and Guest Speakers**
7:30-9:30 p.m.—Location to be announced
(New Jersey Institute of Ultrasound in Medicine and AMNJ)
- 14 The Middle Age Period**
- 21 Vertigo ENG in Psychiatry**
- 28 Sleep Disorders**

- 12 noon-1 p.m.—Carrier Foundation, Belle Mead
(The Carrier Foundation)
- 15- Cardiac Symptoms and Arrhythmias**
- 17** Cherry Hill Hyatt House, Cherry Hill
(International Medical Education Corporation and AAFP)
- 15 Symbol Process in Symbol Formation**
8:30-10:30 p.m.—Hackensack Hospital
(New Jersey Psychoanalytic Society and AMNJ)
- 15 Heart Disease in the Neonate**
8:15-10:30 a.m.—Overlook Hospital, Summit
(Overlook Hospital and AMNJ)
- 16 Urology for the Non-Urologist**
- 17** 9 a.m.-4:40 p.m.
9 a.m.-1 p.m.—Rutgers Medical School, Piscataway
(CMDNJ, AMNJ and AAFP)
- 19 Fluid and Electrolyte Imbalance**
11:30 a.m.-12:30 p.m.—St. Mary's Hospital, Orange
(St. Mary's Hospital and AMNJ)
- 19 Proper Use of Antibiotics**
8:30-9:30 p.m.—Omar's Restaurant, Saddle River Rd., Fair Lawn
(Fair Lawn Memorial Hospital and AMNJ)
- 20 Recent Advances in Medical Oncology**
- 27 Risk Factors in Cancer**
9-11 a.m.—Middlesex General Hospital, New Brunswick
(Middlesex General Hospital, AMNJ and AAFP)
- 20 Colon and Rectal Cancer**
1-2 p.m.—Trenton Psychiatric Hospital
(Trenton Psychiatric Hospital and AMNJ)
- 20 Radiotherapy Section Dinner Meeting**
6:30 p.m.—The Manor, West Orange
(AMNJ)
- 21 The Acute Abdomen in the Newborn**
7:15-10:15 p.m.—Hospital Center at Orange
(Diagnostic Radiology Section for Northern New Jersey and AMNJ)
- 23 Critical Care Management (Symposium)**
No time given—Saint Barnabas Medical Center, Livingston
(Saint Barnabas Medical Center and AAFP)
- 26 Surgical Repair of Cleft Lip and Palate**
8-10 p.m.—Englewood Club, Englewood
(Englewood Surgical Society and AMNJ)
- 27 Drug Addiction**
2-3 p.m.—Ancora Psychiatric Hospital
(Ancora Psychiatric Hospital and AMNJ)
- 27 Advances in Nephrology in 1978**
8:30 a.m.-2:30 p.m.—Helene Fuld Medical Center, Trenton
(Helene Fuld Medical Center, Nephrology Society of New Jersey and AMNJ)

- 27 **Life and Death Decisions**
1-3 p.m.—Hoffmann-La Roche, Inc., Nutley
(*AMNJ*)
- 27 **Life Threatening Dermatoses**
9 a.m.-5 p.m.—Englewood Hospital
(*Englewood Hospital and AMNJ*)
- 27 **Neuropathology Conferences**
8-9:15 a.m.—New Jersey Medical School, Newark
(*CMDNJ and AMNJ*)
- 27 **Preventive Medicine in the Elderly**
1-2 p.m.—VA Hospital, Lyons
(*VA Hospital and AMNJ*)
- 29 **The Practicing Physician's Role in the**
- 30 **Management of the Neurologically Impaired**
9 a.m.-5:15 p.m.—Holiday Inn, Toms River
Garden State Rehabilitation Hospital, The Center to Promote Health Care Studies, AMNJ and AAFP
- 30 **Critical Care Management (Workshop)**
No time given—Saint Barnabas Medical Center, Livingston
(*Saint Barnabas Medical Center and AAFP*)
- Oct.
- 2 **Resistance to Change in a Narcissistic Man**
8-10 p.m.—9 Marquette Rd., Upper Montclair
(*Essex Psychiatric Seminar and AMNJ*)
- 3 **Proper Use of Blood Gases**
8-9 p.m.—Burdette Tomlin Memorial Hospital, Cape May Court House
(*Burdette Tomlin Memorial Hospital and AMNJ*)
- 3 **Complications of Vascular Surgery**
5-6 p.m.—Rutgers Medical School, Piscataway
(*CMDNJ and AMNJ*)
- 3-7 **Clinical/Histopathological Overview of Obstetrics/Gynecology**
Begins Oct. 3-9 a.m.—Waldorf Astoria, New York
(*St. Barnabas Medical Center and AMNJ*)
- 4 **Continuing Education in Psychiatry**
- 11 1-3 p.m.—Bergen Pines County Hospital
(*Bergen Pines Hospital and AMNJ*)
- 18
- 25
- 4 **Clinical Pathology Grand Rounds**
- 11 12 noon-1 p.m.—New Jersey Medical School, Newark
(*CMDNJ and AMNJ*)
- 18
- 25 **Grand Grounds and Case Presentations**
- 11 2-4 p.m.—Rotating between Martland, Newark Beth Israel, St. Michael's, St. Joseph's Hospitals and Jersey City Medical Center
(*CMDNJ and AMNJ*)
- 4 **Bone Scanning**
- 11 **Recurrent Urinary Tract Infections in Older Patients**
- 18 **Treatment of Uremia**
- 25 **Radiology-Pathology Conference**
11:30 a.m.-1:30 p.m.—Rahway Hospital
(*Rahway Hospital and AAFP*)
- 4 **Pre-Hospital Coronary Care**
- 18 **Granulomatous Diseases of the Bowel**
- 25 **Cryosurgery**
1-3 p.m.—Christ Hospital, Jersey City
(*Christ Hospital and AMNJ*)
- 4 **Environmental Cancer In New Jersey, 1978**
- 18 **Masks of Depression**
- 25 **Sarcoidosis and other Granulomatous Disorders**
9-11 a.m.
(*Middlesex General Hospital, AMNJ and AAFP*)
- 4 **Lectures in Obstetrics and Gynecology**
8-10 p.m.—Location varies
(*CMDNJ and AMNJ*)
- 4 **Cardiology: Pre-Hospital Coronary Care**
1-3 p.m.—Christ Hospital, Jersey City
(*Christ Hospital and AMNJ*)
- 4 **Colitis: Diagnosis and Management**
10:30 a.m.-12 noon—St. Mary's Hospital, Passaic
(*St. Mary's Hospital and AMNJ*)
- 4 **Geriatrics-Syndromes**
- 18 **Sexual Dysfunction**
1-3 p.m.—Ancora Psychiatric Hospital, Hammonton
(*Ancora Psychiatric Hospital and AMNJ*)
- 5 **Psychiatric Lecture Series**
- 12 11 a.m.-12 noon—Greystone Park Psychiatric Hospital
- 19
- 26
- 5 **Grand Grounds and Case Presentations**
- 12 4-5 p.m.—Martland Hospital, Newark
(*CMDNJ and AMNJ*)
- 19
- 26
- 6 **Diagnostic and Therapeutic Problems in Orthopedics**
- 13
- 27 7:30-9:30 a.m.—Alexian Brothers Hospital, Elizabeth
(*Alexian Brothers Hospital*)
- 6 **Congestive Heart Failure**
8:30-9:30 a.m.—United Hospitals of Newark
(*United Hospitals of Newark and AMNJ*)
- 10 **Cardiac Arrhythmias**
- 17 **Congestive Heart Failure**
- 24 **Coronary Artery Disease**
11 a.m.-12 noon—Greystone Park Psychiatric Hospital
(*Greystone Park Psychiatric Hospital and AMNJ*)
- 11 **Medical Aspects of Psychosomatic Illness—Part III**
- 25 **Family Therapy—Part I**
3:15-4:15 p.m.—Fair Oaks Hospital, Summit
(*Fair Oaks Hospital and AMNJ*)
- 11 **Alcoholism**
1:30-2:30 p.m.—John E. Rummells Hospital, Berkeley Heights
(*John E. Rummells Hospital and AMNJ*)
- 12 **Care for the Spinal Cord Injured**
1-3 p.m.—VA Hospital, East Orange
(*VA Hospital and AMNJ*)
- 12 **Women's Fear of Being Fat**
8:30-10:30 p.m.—Hackensack Hospital
(*New Jersey Psychoanalytic Society and AMNJ*)
- 12 **Case Presentations and Guest Speakers**
7:30-9:30 p.m.—Location to be announced
(*New Jersey Institute of Ultrasound in Medicine and AMNJ*)
- 17 **Current Chemotherapy**
7-8 p.m.—Irvington General Hospital
(*Irvington General Hospital and AMNJ*)
- 17 **Laboratory Interpretations**
11:30 a.m.-12:30 p.m.—St. Mary's Hospital, Orange
(*St. Mary's Hospital and AMNJ*)
- 17 **Medical Genetics**
2-3 p.m.—Ancora Psychiatric Hospital, Hammonton
(*Ancora Psychiatric Hospital and AMNJ*)
- 18 **Emergency Medical Care**
1-2 p.m.—Trenton Psychiatric Hospital
(*Trenton Psychiatric Hospital and AMNJ*)
- 19 **Double Contrast Examination of the Upper GI Tract**
7:15-10:15 p.m.—Hospital Center at Orange
(*Diagnostic Radiology Section for Northern New Jersey and AMNJ*)
- 20 **Recent Advances in Perinatology**
8:15-10:30 a.m.—Overlook Hospital, Summit
(*Overlook Hospital and AMNJ*)
- 24 **Drug Interactions**
8-10 p.m.—The Englewood Club
(*Englewood Surgical Society and AMNJ*)
- 25 **Neuropathology Conferences**
8-9:15 a.m.—New Jersey Medical School, Newark
(*CMDNJ and AMNJ*)
- 26 **Advances in Antibiotics and Viral Chemotherapy**
12 noon-1 p.m.—Carrier Foundation, Belle Mead
(*The Carrier Foundation*)
- Nov.
- 1 **Continuing Education in Psychiatry**
- 8 1-3 p.m.—Bergen Pines County Hospital
- 15 Paramus
- 22
- 1 **Emergency Care: Medical**
1-3 p.m.—Christ Hospital, Jersey City
(*Christ Hospital and AMNJ*)
- 1 **Lectures in Obstetrics and Gynecology**
8-10 p.m.—Location varies
(*CMDNJ and AMNJ*)
- 1 **Diagnosis of Anemic Patient**
- 29 **Clinical Immunology**
10:30 a.m.-12 noon—St. Mary's Hospital, Passaic
(*St. Mary's Hospital and AMNJ*)
- 1 **Sexual Dysfunction-Case Histories**
- 15 **Sexual Dysfunction-Research**
- 29 **Psychiatric Emergencies**
1-3 p.m.—Ancora Psychiatric Hospital
(*Ancora Psychiatric Hospital and AMNJ*)
- 1 **Hypertension**
- 8 **CEA Program**
- 15 **Chemotherapy of Breast Tumors**
- 22 **Chartmanship**
- 29 **Radiology-Pathology Conference**
11:30 a.m.-1:30 p.m.—Rahway Hospital
(*Rahway Hospital and AAFP*)
- 1 **Grand Rounds and Case Presentations**
- 8 2-4 p.m.—Rotating between Martland, Newark Beth Israel, St. Michael's, St. Joseph's Hospitals and Jersey City Medical Center
(*CMDNJ and AMNJ*)
- 1 **Clinical Pathology Grand Rounds**
- 8 12 noon-1 p.m.—New Jersey Medical School, Newark
(*CMDNJ and AMNJ*)
- 15
- 22
- 29
- 1 **Spectrum of Arthritis**
- 8 **Selection of Therapy for Aortic Valve Disease**
- 15 **Anaerobic Infections**
- 22 **Some Areas of Controversy in Cardiology**
- 29 **Drug-Induced Psychoses**

- 9-11 a.m.—Middlesex General Hospital, New Brunswick
(*Middlesex General Hospital, AMNJ and AAFP*)
- 2 **Education in Human Sexuality**
- 9 **Conceptual Problems in Diagnosis**
12 noon-1 p.m.—Carrier Foundation, Belle Mead
(*The Carrier Foundation*)
- 2 **Psychiatric Lecture Series**
9 11 a.m.-12 noon—Greystone Park Psychiatric Hospital
16 (*Greystone Park Psychiatric Hospital and AMNJ*)
- 2 **Grand Rounds and Case Presentations**
9 4-5 p.m.—Martland Hospital, Newark
16 (*CMDNJ and AMNJ*)
- 30
- 3 **Diagnostic and Therapeutic Problems in**
- 10 **Orthopedics**
24 7:30-9 a.m.—Alexian Brothers Hospital, Elizabeth
(*Alexian Brothers Hospital*)
- 3 **Colitis**
8:30-9:30 a.m.—United Hospitals of Newark
(*United Hospitals of Newark and AMNJ*)
- 4 **Critical Care Medicine**
9 a.m.-1 p.m.—North Jersey Country Club, 584 Hamburg Turnpike, Wayne
(*Greater Paterson General Hospital and AMNJ*)
- 6 **Psychiatric Lecture Series**
8-10 p.m.—4 Garden Place, Nutley
(*Essex Psychiatric Seminar and AMNJ*)
- 7 **An In-Depth View of the Vagus**
5-6 p.m.—Rutgers Medical School, Piscataway
(*CMDNJ and AMNJ*)
- 8 **Family Therapy—Part II**
- 22 **Family Therapy—Part III**
3:15-4:15 p.m.—Fair Oaks Hospital, Summit
(*Fair Oaks Hospital and AMNJ*)
- 8 **Drug Addiction**
1:30-2:30 p.m.—John E. Runnells Hospital, Berkeley Heights
(*John E. Runnells Hospital and AMNJ*)
- 9 **Outpatient Treatment of Burns**
8-9 p.m.—Zurbrugg Memorial Hospital, Riverside
(*Burlington County Medical Society and AMNJ*)
- 9 **Case Presentations and Guest Speakers**
7:30-9:30 p.m.—Location to be announced
(*New Jersey Institute of Ultrasound in Medicine and AMNJ*)
- 14 **Malpractice**
2-3 p.m.—Ancora Psychiatric Hospital, Hammonton
(*Ancora Psychiatric Hospital and AMNJ*)
- 14 **Adrenal Diseases**
- 21 **Diabetes**
- 28 **Obesity**
11 a.m.-12 noon—Greystone Park Psychiatric Hospital
(*Greystone Park Psychiatric Hospital and AMNJ*)
- 15 **Diagnosis and Management of GIT Bleeding**
1-2 p.m.—Trenton Psychiatric Hospital
(*Trenton Psychiatric Hospital and AMNJ*)
- 15 **Recent Advances in Gastroenterology**
9 a.m.-5 p.m.—VA Hospital, East Orange
(*VA Hospital and AMNJ*)
- 16 **CAT Scanning**
7:15-10:15 p.m.—Hospital Center at Orange
(*Diagnostic Radiology Section for Northern New Jersey and AMNJ*)
- 17 **Recent Advances in Genetic Diagnosis and Counseling**
8:15-10:30 a.m.—Overlook Hospital Summit
(*Overlook Hospital and AMNJ*)
- 21 **Gastro-Intestinal Bleeding**
7-8 p.m.—Irvington General Hospital
(*Irvington General Hospital and AMNJ*)
- 21 **Current Chemotherapy**
11:30 a.m.-12:30 p.m.—St. Mary's Hospital, Orange
(*St. Mary's Hospital and AMNJ*)
- 22 **Neuropathology Conferences**
8-9:15 a.m.—New Jersey Medical School, Newark
(*CMDNJ and AMNJ*)
- 28 **Malignant Hyperthermia**
8-10 p.m.—The Englewood Club Englewood
(*Englewood Surgical Society and AMNJ*)
- Dec.
- 1 **Proper Use of Antibiotics**
8:30-9:30 a.m.—United Hospitals of Newark
(*United Hospitals of Newark and AMNJ*)
- 1 **Diagnostic and Therapeutic Problems in**
- 8 **Orthopedics**
22 7:30-9 a.m.—Alexian Brothers Hospital Elizabeth
(*Alexian Brothers Hospital*)
- 4 **Psychiatric Lecture Series**
8-10 p.m.—192 Chittenden Rd., Clifton
(*Essex Psychiatric Seminar and AMNJ*)
- 5 **Gastrointestinal Bleeding**
8-9 p.m.—Burdette Tomlin Memorial Hospital, Cape May Courthouse
(*Burdette Tomlin Memorial Hospital and AMNJ*)
- 5 **Colo-rectal Carcinoma**
5-6 p.m.—Rutgers Medical School Piscataway
(*CMDNJ and AMNJ*)
- 5 **Medical Emergency Care**
- 12 **Colitis**
- 19 **Medical Genetics**
11 a.m.-12 noon—Greystone Park Psychiatric Hospital
(*Greystone Park Psychiatric Hospital and AMNJ*)
- 6 **Continuing Education in Psychiatry**
13 1-3 p.m.—Bergen Pines County Hospital, Paramus
20 Paramus
27 (*Bergen Pines Hospital and AMNJ*)
- 6 **Genetics**
1-3 p.m.—Christ Hospital, Jersey City
(*Christ Hospital and AMNJ*)
- 6 **Lectures in Obstetrics and Gynecology**
8-10 p.m.—Location Varies
(*CMDNJ and AMNJ*)
- 6 **Sepsis and Endotoxic Shock**
10:30 a.m.-12 noon—St. Mary's Hospital, Passaic
(*St. Mary's Hospital and AMNJ*)
- 6 **Psychiatric Emergencies**
- 20 **Antianxiety and Antidepressants**
- 1-3 p.m.—Ancora Psychiatric Hospital Hammonton
(*Ancora Psychiatric Hospital and AMNJ*)
- 6 **Systemic Mycoses**
- 13 **Nutritional Issues in Clinical Medicine**
- 20 **Endocrine Aspects of Aging**
9-11 a.m.—Middlesex General Hospital New Brunswick
(*Middlesex General Hospital, AMNJ and AAFP*)
- 6 **The Anxiety Syndrome**
- 13 **Antibiotic Rx**
- 20 **Common Hematologic Problems**
11:30 a.m.-1:30 p.m.—Rahway Hospital
(*Rahway Hospital and AAFP*)
- 6 **Grand Rounds and Case Presentations**
13 2-4 p.m.—Rotates between Martland, Newark Beth Israel, St. Michael's, St. Joseph's Hospitals and Jersey City Medical Center
20 (*CMDNJ and AMNJ*)
- 27
- 6 **Clinical Pathology Grand Rounds**
13 12 noon-1 p.m.—New Jersey Medical School, Newark
20 (*CMDNJ and AMNJ*)
- 27
- 7 **Psychiatric Lecture Series**
14 11 a.m.-12 noon—Greystone Psychiatric Hospital
21 (*Greystone Psychiatric Hospital and AMNJ*)
- 7 **Grand Rounds and Case Presentations**
14 4-5 p.m.—Martland Hospital, Newark
21 (*CMDNJ and AMNJ*)
- 28
- 7 **Psychiatric Ethics**
- 14 **Hysterical Dissociation**
12 noon-1 p.m.—Carrier Foundation Belle Mead
(*The Carrier Foundation*)
- 12 **Clinical Pharmacology**
2-3 p.m.—Ancora Psychiatric Hospital Hammonton
(*Ancora Psychiatric Hospital and AMNJ*)
- 12 **Pulmonary Disease—Proper Use of Blood Gases**
8:30-9:30 p.m.—Omar's Restaurant, Saddle River Road, Fair Lawn
(*Fair Lawn Memorial Hospital and AMNJ*)
- 14 **Case Presentations and Guest Speakers**
7:30-9:30 p.m.—Location to be announced
(*New Jersey Institute of Ultrasound in Medicine and AMNJ*)
- 15 **Management of the Juvenile Diabetic**
8:15-10:30 a.m.—Overlook Hospital Summit
(*Overlook Hospital and AMNJ*)
- 19 **Cardiopulmonary Complications of the Surgical Patient**
8-10 p.m.—The Englewood Club Englewood
(*Englewood Surgical Society and AMNJ*)
- 19 **Adrenal Diseases**
11:30 a.m.-12:30 p.m.—St. Mary's Hospital, Orange
(*St. Mary's Hospital and AMNJ*)
- 20 **Diagnosis and Management of Shock**
1-2 p.m.—Trenton Psychiatric Hospital
(*Trenton Psychiatric Hospital and AMNJ*)
- 27 **Neuropathology Conferences**
8-9:15 a.m.—New Jersey Medical School, Newark
(*CMDNJ and AMNJ*)

Dr. Henry Briggs

One of Essex County's senior members, Henry Briggs, M.D., died on June 6. Born in 1896 in Lexington, Massachusetts, Dr. Briggs graduated from Harvard Medical School in 1927 and pursued graduate work in orthopedic surgery. He was a Fellow of the American College of Surgeons, of the International College of Surgeons, and of the American Academy of Orthopedic Surgeons, as well as a diplomate in orthopedic surgery. Prior to his retirement to Fort Lauderdale, Florida in 1970, Dr. Briggs had served as attending orthopedic surgeon at Overlook Hospital in Summit, and as a consultant at All Soul's Hospital in Morristown, Riverside Hospital in Boonton, East Orange General Hospital, and Memorial Hospital in Orange.

Dr. Rachel Burstein

Word has just been received of the death on October 24, 1976 of Rachel Burstein, M.D. Born in Russia, Dr. Burstein received her medical degree at the University of Geneva School of Medicine, Switzerland, in 1935. She pursued graduate work in dermatology and syphilology, becoming board certified in those specialties in 1949. She became a member of the Essex County component in 1952 and established an office in East Orange. Dr. Burstein was a diplomate in dermatology and had been a member of the American Academy of Dermatology, the American Medical Women's Association, and the Academy of Medicine of New Jersey. She had been affiliated with Newark Beth Israel Medical Center.

Dr. Theodore Gebirtig

We have just learned of the death on March 7 of Theodore Gebirtig, M.D., a senior member of our Morris County component. Born at the turn of the century in Toronto, Canada, Dr. Gebirtig received his medical degree from the University of Toronto's School of Medicine in 1924, and completed post-

graduate studies in London, England, in psychiatry, neurology, and psychoanalysis. He became assistant director of Northern New Jersey Mental Hygiene Clinics, later becoming director. During World War II he served as neuro-psychiatrist and chief of medicine of the 96th Evacuation Hospital with the United States Army, and was awarded five major campaign stars. Dr. Gebirtig became a member of the staff of Greystone Park Psychiatric Hospital in 1928, becoming assistant superintendent in 1950. He was a Fellow of the American Psychiatric Association, a past-president of the New Jersey Association of Mental Hygiene Clinics, and a member of the New Jersey Neuro-psychiatric Association.

Dr. Arthur A. Hartley

On June 3, Arthur A. Hartley, M.D., a member of our Camden County component, died at West Jersey Hospital, Eastern Division, in Voorhees. A native of New Jersey, born in 1908, Dr. Hartley was graduated from Hahnemann Medical College, class of 1934, and pursued graduate work in gynecology, becoming board certified in that specialty. He had been attending gynecologist at West Jersey Hospital for many years and had been president of the staff at the Northern Division in Camden. Dr. Hartley formerly had been on the staff at Hahnemann Hospital in Philadelphia and was a member of the faculty there as assistant professor of gynecology. He was a Fellow of the American College of Surgeons and of the American College of Obstetricians and Gynecologists. During World War II Dr. Hartley served with the medical department of the U.S. Navy.

Dr. Constantine E. Iliades

A well-known otolaryngologist from Essex County, Constantine E. Iliades, M.D., died on June 3. Born in 1917 on the island of Samos, Greece, Dr. Iliades graduated from the medical school of

the University of Athens in 1941. He emigrated to this country after serving in the British Navy during World War II. He established offices in both Newark and Montclair, later moving to Glen Ridge where he was practicing at the time of his death. Dr. Iliades was assistant clinical professor of otolaryngology at the New Jersey Medical School in Newark, and had affiliations with St. Michael's Medical Center in Newark, Mountainside Hospital in Montclair, and the Veterans Administration Hospital in East Orange. He was a Fellow of the American College of Surgeons, the Royal College of Surgeons, and the Royal Society of Medicine, and a diplomate of the Pan-American Medical Association's Otolaryngological Section. Dr. Iliades had been a member of a long list of national and international societies including the Pan-American Association of Oto-Rhino-Laryngology and Broncho-Esophagology, the Hellenic Oto-Rhino-Laryngologic Bronchologic and Phoniatic Society, and the American Council of Otorhinolaryngology. He also was surgeon consultant to the United States Navy and a surgeon admiral consultant to the Hellenic Navy.

Dr. Granville L. Jones

Granville L. Jones, M.D., former clinical director of the State Hospital at Marlboro died suddenly on April 30 of a ruptured aorta. A native of Texas, Dr. Jones earned his medical degree from the University of Arkansas in 1928. He pursued residencies in psychiatry becoming board certified in that field. He left New Jersey for about ten years to serve as superintendent of Eastern State Hospital in Williamsburg, Virginia and then of the Arkansas State Hospital in Little Rock. He returned to New Jersey in 1961 to assume the position of assistant medical director of the New Jersey Neuropsychiatric Institute in Princeton and was coordinator of the New Jersey Drug Addiction Program. For six years prior to retirement in 1977, Dr. Jones was director of research and education

at Fair Oaks Hospital in Summit. He was a Fellow of the American College of Physicians and of the American Psychiatric Association. Dr. Jones was presently living in Dunedin, Florida.

Dr. George Lamzaky

On June 11, George G. Lamzaky, M.D., a member of our Hudson County component, died suddenly at his home. Born in 1919 in Russia, Dr. Lamzaky was graduated from the medical school at the University of Munich in Germany in 1953 and soon after emigrating to the United States established a practice in general medicine and surgery in Jersey City and later in North Bergen. He was affiliated with Christ Hospital in Jersey City and North Hudson Hospital in Weehawken.

Dr. Anthony J. Majeski

At the untimely age of 52, Anthony J. Majeski, M.D., a general practitioner with offices in Brick Township, died at his home on June 18 after a long illness. Born in Newark, Dr. Majeski received his medical degree from the University of Leiden, Holland in 1953, and returned to this country to establish a practice in Toms River. He was a member of our Ocean County component. Before changing to general medicine in 1969, Dr. Majeski had specialized in obstetrics and gynecology, and was affiliated with Community Memorial Hospital in Toms River and Paul Kim-

ball Hospital in Lakewood. He was a captain in the medical corps of the United States Army.

Dr. William Ashton Roberts

Word was received on May 17 of the death of William A. Roberts, M.D., one of Essex County's senior members who had retired to Rehoboth Beach, Delaware in 1971. Dr. Roberts earned his doctorate in medicine from the University of Pennsylvania School of Medicine, class of 1929, and practiced general medicine in Caldwell. He had been on the staff at Mountainside Hospital, Montclair as an attending in obstetrics and at Montclair Community Hospital as an associate attending in surgery. Dr. Roberts was a member of the Academy of Medicine of New Jersey. He was 77 years old at the time of his death.

Dr. Ralph A. Ruffer

Word has been received of the death on May 18 of Ralph A. Ruffer, M.D., a member of our Sussex County component. Graduated from Georgetown Medical School in 1935, Dr. Ruffer was a general practitioner (with special interest in pediatrics) in Union City until moving to Franklin in 1962. He had been on the staff at St. Mary's Hospital in Hoboken. Dr. Ruffer was a Fellow of the American Academy of Family Practice. He was 70 years old at the time of his death.

Dr. Isadore Shechner

Isadore Shechner, M.D., a senior member of our Essex County component, died at his home on April 20. Born in 1906 in New York City, Dr. Shechner graduated from the University of Aberdeen School of Medicine in Scotland in 1934 and returned to this country to establish an office for the practice of general medicine in 1936. Dr. Shechner had been affiliated with St. James Hospital in Newark.

Dr. Eugene L. Timins

At the untimely age of 35, Eugene L. Timins, M.D., who became a member of our Morris County component as a transfer from the District of Columbia Society, just a year and a half ago, died on June 2 at Morristown Memorial Hospital after a short illness. A native of New Jersey, Dr. Timins earned his medical degree from Jefferson Medical College in 1969 and after internship at the University's Hospital pursued a residency in general surgery at Jeanes Hospital in Philadelphia, and in neurological surgery at George Washington University Hospital. He was engaged as research physiologist in neuroradiology at the National Institutes of Health before coming to Morristown to open a private practice in neurosurgery. He was affiliated with Dover General Hospital in Dover and St. Clare's Hospital in Denville.

Primary Prevention: An Idea Whose Time Has Come.

Donald C. Klein, and S. E. Goldston.
Washington, D.C., U.S. Government
Printing Office, 1977. Pp. 203. (\$3.00)

This volume contains the proceedings of the Pilot Conference on Primary Prevention (of mental illness) held in 1976 at Temple University in Philadelphia.

Organized into seven sections beginning with a description of the evolving conference design and its implementation, moving through the texts of the three formal papers presented at the conference dealing with trends in preventive programming, basic strategies in designing preventive interventions, and ways of formulating and evaluating achievable objectives for primary prevention, it concludes with recommendations arising from the conference project. The final fifty-two pages consist of a series of appendices related mainly to conference planning, faculty and evaluations.

Goldston states: "We are here to talk, learn, and plan about (positive) mental health, not mental illness . . ." Later, he asks—"how well is the community?" rather than "how sick?" That being the case, one wonders why the use of the term "prevention?" For surely it is not positive mental health or the well community that is to be prevented but indeed mental illness as an individual and public health problem. In his view there are four distinct major frameworks for conceptualizing and classifying primary preventive efforts. The latter he defines as "actions which either (1) anticipate a disorder and/or (2) foster optimal health." The four are primary prevention of mental illnesses of known etiology, primary prevention of mental illnesses of unknown etiology, primary prevention of emotional distress, maladaptation, maladjustment, needless psychopathology and human misery, and the promotion of mental health. The

first two are eliminated (!) as related to the conference while the two latter frameworks become the focus. Inevitably the approach is a psycho-socio-cultural-educational one in which crisis theory, crisis intervention, and anticipatory guidance are especially relevant. What we are dealing with is not psychiatric illness. Rather, it is with problems of living which, acting as stressors, may precipitate psychiatric illness in predisposed or susceptible individuals.

The organizational structure proposed for providing the primary preventive services is the community mental health center. This immediately raises among other items a major philosophical issue: that is, the tendency of individuals in public office and in governmental agencies to solve problems by centralization. In so doing, not only is a subliminal encouragement given to totalitarian operations and away from democratic, pluralistic options but there is a simultaneous denial of the existence of private and other non-public supportive activities which have, for many years, been the pluralistic options providing primary preventive services in their communities. These options have been the extended family, neighbors and friends, medical practitioners, the clergy, the various social agencies, fraternal orders, and others. Some of these have gone with the wind such as the neighborhood and neighbors, the extended family, and the clergy. It is questionable, however, whether essentially social functions should be assigned to health delivery systems simply because the former have implications for better mental health.

Throughout the text references are made to the gains made in public health through primary preventive programs. However, there is, in reality, no direct parallel to the problem of public mental health. For the latter is incredibly complex and involves issues and solutions often far out of the hands of the medical professional or of any combination of health and mental health professionals. For example, reference is made to a number of possible "high-risk casualty groups—needing protection, such as

the poor—the unemployed—." One can only be reminded of the ancient adage: "First, the stomach; then, the heart." More surely, the primary preventive way to deal with the poor and the unemployed is to provide gainful employment and thus to build self-esteem and mental health.

Perhaps the limitations of secondary and tertiary clinical intervention as well as the ever-present imperative for change, progress, and one-upmanship led to the optimism about primary prevention in mental health. Whether or not one is skeptical about this subject, the book is a useful summary of important concepts and issues on the subject of primary prevention with the limitations noted above. In particular, Hollister's paper on "Basic Strategies in Designing Primary Prevention Programs" and Bloom's paper on "Evaluating Achievable Objectives for Prevention" are recommended as well written and make the publication well worth reading by psychiatrists and other mental health professionals interested in primary prevention, consultation, and education.

Arnold M. Kallen, M.D.

Health of the People: A Review of Health Services in the Republic of South Africa

Department of Health, Johannesburg, South Africa, Chris van Rensburg Publications, 1977. Pp. 140. Illustrated (no price given)

The Health of the People, "A review of Health Services in the Republic of South Africa in the mid-seventies," is a beautifully photographed travelogue-like trip through South Africa's entire health care system.

The first part of the book presents a

historical perspective of the country and briefly describes the organization of the system and the resources—money, manpower, and facilities—available.

Further discussion deals with how services are provided beginning with comprehensive, community-oriented primary health care in clinics and health centers and progressing to small community hospitals for secondary care and larger medical center specialty institutions for tertiary care. Basic public health activities such as maternal and child health, communicable disease control, family planning, genetic counseling and nutrition services are described as is a very strong health education policy which states “. . . that all health workers should devote one-fifth of their time to health education. . .”

There is also a look at the development of practitioners and advancement of knowledge. The specific educational programs offered and the qualifications of the various health workers are outlined and the significant research activities that have occurred are discussed.

The book closes with a view toward future developments and emphasizes,

although rather subtly, the emergence of black consciousness over white supremacy.

This publication is well illustrated throughout with graphs and tables that highlight the narration, and is recommended to those interested in international health, public health, and health-care organization.

Donald S. Kwalick, M.D.

The Economics of Medical Malpractice

Simon Rottenberg, editor. Washington, D.C., American Enterprise Institute for Public Policy Research, 1978. Pp. 293, (Softcover—\$5.75; hardcover—\$10.75)

This book examines the impact the medical malpractice crisis has had on the delivery of health care and our economic structure. The format of the book as a compilation of essays provides the reader with considerable information concerning the complex intertwining of malpractice problems with other aspects of the medical care system. The reader

is provided with insight into the effects the medical malpractice problem has on the delivery of care as well as the impact the problem has had on the traditional tort system of dispute resolution. Many of the authors examine alternate approaches to liability for medical accidents both as a means of compensation and as a means for assuring the quality of medical care. The book does not examine the medical malpractice problem exclusively in terms of the market system as a whole, but also provides data concerning the effects of the problem upon insurers, providers, and recipients of health care.

Many of the authors utilize an empirical method of analysis that may appear technical and detailed to the physician-reader. It should be recognized, however, that empirical, factual studies concerning medical malpractice are necessary in order to remove the emotionalism from this topic and to obtain evidence necessary to evaluate the issues effectively.

This book is essential reading for all those interested in a thorough review of the underlying issues concerning medical malpractice. James E. George, M.D.

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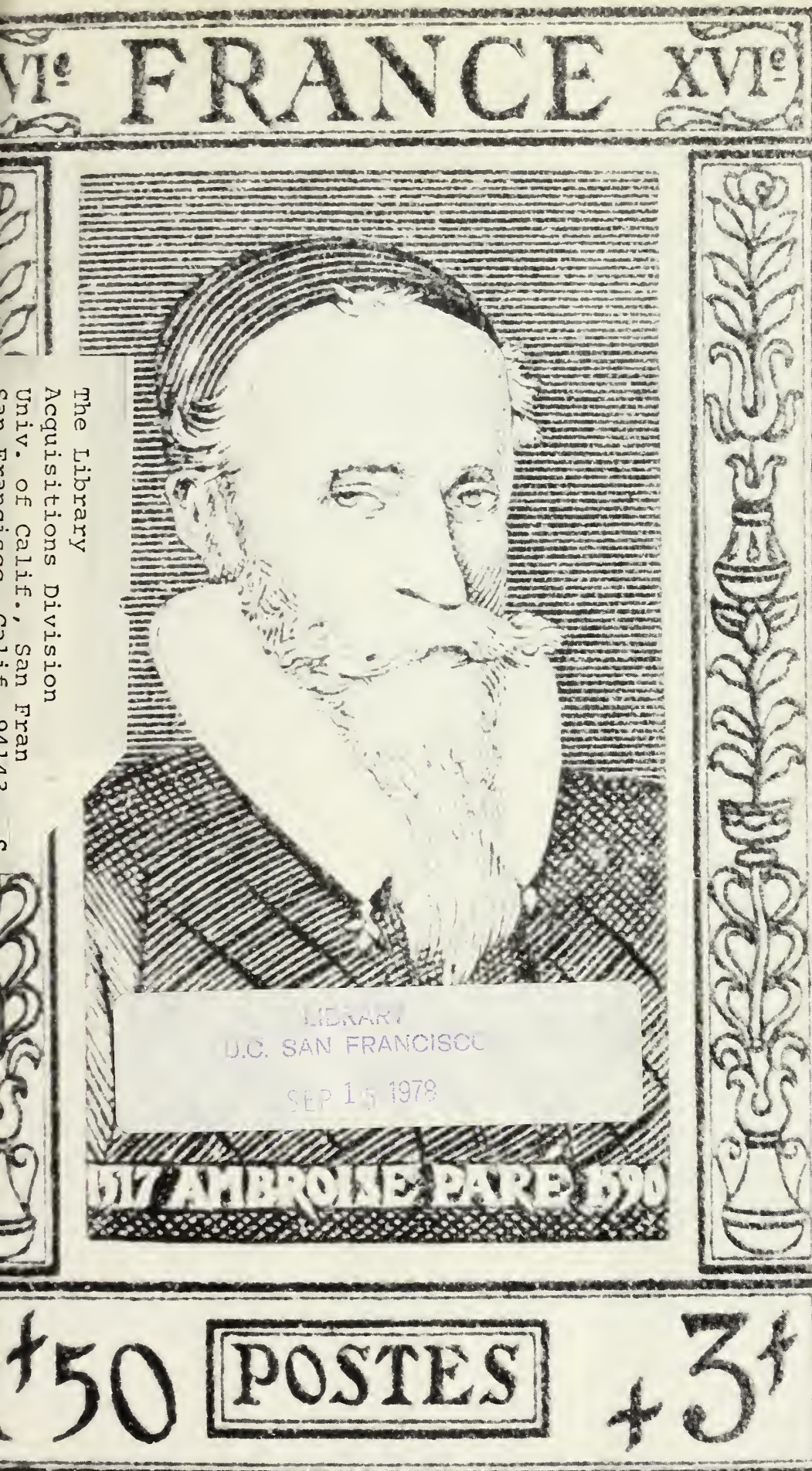
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The photograph on our cover of the stamp honoring Ambrose Paré (1517-1590), French surgeon, was supplied by Joseph H. Kler, M.D., New Brunswick, retired ophthalmologist, philatelist, medical historian, and former chairman of MSNJ's Public Relations Council—see editorial, page 657, and personal note on Dr. Kler, page 715.



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Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals

Use in Pregnancy: Use of minor tranquilizers during first trimester should always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or over-

hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice, periodic blood counts and liver function tests advisable during long-term therapy.

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Dixon WJ, Massey FJ: *Introduction to Statistical Analysis*. New York, McGraw-Hill, 1969, pp 00-00.

Accident Facts. Chicago, Illinois. National Safety Council, 1974.

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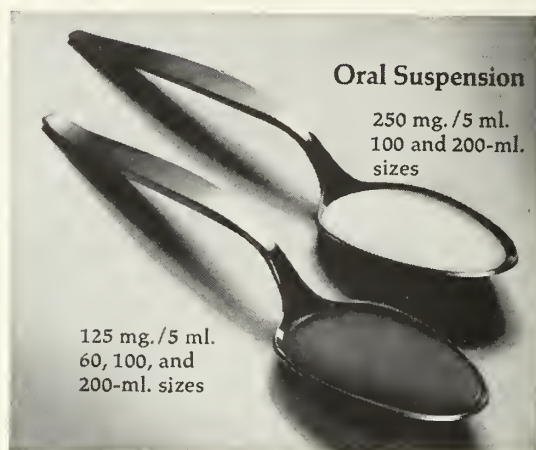
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Medicine on Stamps*

The stamp reproduced on the cover of this issue was selected by Dr. Joseph Kler, a New Jersey medical philatelist with an international reputation. Dr. Kler described it as “a picture of my favorite medical stamp because of Ambrose Paré’s stature and accomplishments.”

“Ambrose Paré (1517-1590) was born in France of humble parentage. In 1532 he was apprenticed to a barber surgeon in Paris. He studied at the Hôtel Dieu and then joined the French army—attaching himself to all the leading army surgeons of the time until he became the king’s surgeon. He worked under Jacobus Sylvius and studied anatomy under Vesalius. In 1545 he published his first book, written in French, which was a treatise on the treatment of wounds on the battlefield. In 1549 he published a handbook of anatomy designed for surgeons.

“Paré towered above all other surgeons of his day, becoming the surgeon to four kings. He revolutionized the treatment of traumatic injuries and established the use of ligatures in the control of hemorrhage in wounds and in surgery. He invented many new instruments, introduced massage, artificial limbs and artificial eyes into surgery, suggested syphilis as the cause of aneurysms, and practiced induced labor for serious uterine hemorrhage. His greatest individual

work was his treatise on gunshot wounds. His collected works, *Oeuvres*, were translated into many languages and had a tremendous influence on the progress of surgery.”*

Dr. Kler went on to describe Paré as follows:

“Starting out as a barber surgeon, he had the ability to rationalize and apply in medicine what he learned by observation. His comment—‘I dressed him but God healed him.’—illustrates his character. He discarded Galen’s dictums, stopped using hot oil in gunshot wounds, (was the) first to use ligatures routinely to control hemorrhage, served under five monarchs in France, and was the only protestant spared at St. Bartholomew’s ‘massacre’ by royal decree.

“In my humble opinion he is the founder of modern surgery.”**

Stamps are a permanent record of the world’s history. They transcend international borders and language barriers. Medical stamps are special, and medical philatelists are special medical historians. For more about Joseph Kler see the personal item (page 715) in this issue. A.K.

*Kler JH: *Medicine on Stamps*. New York, Minkus Publications, 1969.

**Personal Communication

Influenza and Pneumococcus Immunization

In this era of preventive medicine, the appropriate use of vaccines especially suitable for adults remains a major weapon. Unfortunately, the fiasco of the national swine flu vaccination program in the United States has created a major public doubt among our citizens. Individually, this has not been the case however.

Neither the Congress nor the New Jersey State government authorities intends to support any major mass immunization program against influenza this year. In fact, it appears that even token financial support for the medically indigent is not forthcoming.

Obviously, such immunization is once more the responsibility of the individual physician. It is important that traditional recognition of the value of *selective* immunization of high-risk individuals not be jeopardized at this particular time because of the public backlash of no confidence in the politically inspired swine flu program.

In addition to influenza vaccine, we now have a safe and effective vaccine against 14 different capsular types of pneu-

mococci*. This preparation represents 80 percent of pneumococcal disease isolates in the United States and Europe. Although there have been more than 80 pneumococcal capsular types identified, the available vaccine contains types 1, 2, 3, 4, 6, 8, 9, 12, 14, 19, 23, 25, 51, and 56 (American classification).

The attempts to develop an effective vaccine against pneumococcal diseases go back to 1911 with clinical trials over a period of 40 years that involved nearly half a million persons in this country and abroad. In 1930, the immunogenicity of pneumococcal capsular polysaccharides was discovered in man and this led to investigations by Maxwell Finland, MacLeod and his associates, and others prior to and during World War II. A study in ten American hospitals initiated in 1967 provided data relative to which pneumococcal capsular types should be included in contemporary vaccines.

*Pneumovax® (Pneumococcal Vaccine, Polyvalent, M.S.D.)

The U.S. Food and Drug Administration deemed the efficacy and safety of the pneumococcal vaccine such that its use should be legalized, so it was licensed and became generally available at the beginning of 1978. The present preparation, which is given as a single 0.5 ml injection, has been reported to produce minor side effects such as transitory local soreness and erythema and occasionally slight fever. No severe reactions to the vaccine have been reported.

The effectiveness of the vaccine seems clear. It can prevent most cases of pneumococcal pneumonia and pneumococcal bacteremia and probably would prove effective in preventing most cases of pneumococcal meningitis. The duration of the protective effect is not known, but antibodies persist as long as five years. Thus, revaccination in less than three to five years is unlikely. The vaccine does not provide a consistent immune response in children less than two years of age, therefore it may fail to prevent otitis media and other pneumococcal infections in this age group.

Pneumococcal vaccine is recommended for patients more than two years old with a high risk of serious pneumococcal infection. The highest risk is probably in patients who have been splenectomized, those with sickle cell anemia, and children with nephrotic syndrome. Others at risk are the elderly and those with diabetes, chronic cardiovascular disease, chronic pulmonary disease, alcoholic cirrhosis, and other chronic diseases. Patients with altered immune re-

sponses due to agammaglobulinemia, lymphoproliferative diseases, or the use of immunosuppressive drugs also have a major risk of serious pneumococcal infection, but they may not respond to the vaccine. The vaccine is *not* recommended for pregnant women and should not be given to patients during a febrile illness.

Influenza vaccines that include the prevalent strains of influenza viruses have been shown to reduce the incidence of infection among recipients of the vaccine for a one to two-year period. In the past, selective immunization of high-risk individuals has been carried out effectively by physicians. The vaccine is indicated for the aged and for patients with diabetes, cardiovascular, pulmonary, renal, and other chronic diseases. Pregnant women who are expected to deliver during the winter months also should be vaccinated. Physicians are familiar with the recommendation that influenza vaccine should be administered in the fall and a single dose usually is sufficient to develop protective antibodies.

New Jersey physicians are urged to offer both influenza vaccine and pneumococcal vaccine to their high-risk patients. As with all such patient-doctor decisions, informed consent is essential, but the ratio of safety and effectiveness to risk of adverse reactions is such that those patients who are at great risk from influenza or pneumococcal infections should accept the vaccines.

A.K.

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If you find yourself intolerably frustrated about the unsavory attitudes of some elected officials, do something about it! Join JEMPAC!

Circumoral pallor, bloodless knuckles, and elevated catecholamines are signs of extreme frustration. The medical profession is too sophisticated to go around kicking cans, and ignoring pent-up anger is bad for your health. So find a better alternative.

The New Jersey Medical Political Action Committee encourages physicians and their families to participate actively in the electoral process. Its board of directors is *non-partisan* and functions to encourage physicians and physician groups throughout the state to support the candidates of *their* choice. The American Medical Political Action Committee (AMPAC), like JEMPAC, never endorses a candidate. It does not compile a voting index by which candidates are rated. The only role it plays is to increase the

opportunity of a candidate to explain his philosophy to the voters. An example of this activity is the wine and cheese function at the annual meeting of MSNJ, where candidates for Governor and Senator from our state came to speak to our membership.

In general, AMPAC and JEMPAC "support candidates who endorse the free enterprise system and constitutional government and who resist the encroachment and interference of government into the lives of its citizens."

Although the New Jersey membership is increasing slowly, the number is pitifully small. Out of 9,261 members in MSNJ, only 330 belong to JEMPAC. If you want to become politically active—and release some pent-up frustration—learn more about JEMPAC. Get a copy of the annual report and an application blank. Write to: JEMPAC Membership Registration, c/o Medical Society of New Jersey, P.O. Box 904, Trenton, New Jersey 08605.

A.K.

213th Annual Meeting

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Atlantic City

Evaluation of Psychogenic Neurologic Signs in Primary Care Practice

MATTHEW MENKEN, M.D., Piscataway*

The differentiation of psychogenic abnormalities of strength and other neurologic functions from similar abnormalities reflecting organic impairment is discussed. Although there are no reliable specific tests, a careful neurologic examination is mandatory. Objective neurologic signs and patterns of impairment known to occur with neurologic illness are the most reliable findings. Certain ancillary diagnostic studies may prove helpful.

Differentiation of organic neurologic signs from psychiatric "conversion" and "hysterical" abnormalities is often difficult. Experienced neurologic clinicians often eschew the tests outlined in the major textbooks¹ because they prove to be unreliable in practice. With a meticulous history and examination, it is usually possible for the neurologist to make a correct diagnosis. Unfortunately, few guidelines are available for the primary care physician or psychiatrist who may lack the depth of personal experience necessary to interpret atypical responses to neurologic testing. There is no absolutely foolproof method of distinguishing organic from functional signs. Many patients have a combination of both, a phenomenon often referred to by clinicians as "elaboration" of their organic illness. This may occur when one or more physicians fail to take the patient's organic complaints as seriously as the patient deems appropriate.

In the analysis that follows, the problem is outlined as it appears in the physician's office or hospital, namely, one or more clinical signs requiring interpretation. No effort is made to separate hysteria from malingering. The goal is to distinguish both of these from organic impairment of the central and peripheral nervous systems.

PARALYSIS OF ONE OR MORE EXTREMITIES

The most reliable differentiating feature in the evaluation of weakness is the presence of objective signs that do not require the patient's participation. Thus, a Babinski sign

elicited in a weak leg is unequivocal evidence of organic impairment as is an alteration in the deep tendon reflexes, or a change in tone on passive motion. The pattern of weakness may be typical of myopathic or neurogenic disease. Thus, the weakness may be predominantly, if not exclusively, proximal or distal in the extremities involved. This pattern would not be anticipated with psychogenic weakness unless the patient has knowledge of anatomy and pathology.

There are countless tests in the literature² that purport to be useful in the differentiation of neurologic and psychogenic weakness. Hoover's sign, Babinski's combined leg flexion test, Bechterew's sign, Ramiste's arm sign, and Neri's pronation sign are just a few. If one assumes that the physician can remember these tests and how to perform them, the results are difficult to interpret even by neurologists. The search for objective signs is the key to proper diagnosis in these cases.

In the presence of pain, patterns of weakness often appear that seem bizarre and functional. The explanation is generally an involuntary effort on the patient's part to avoid pain. Following an orthopedic procedure on a hip or knee, for example, it is not unusual to find that muscle testing of the contralateral leg reveals apparent weakness. With retro-

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peritoneal pathology involving the lumbar plexus, apparent weakness also may appear on the opposite side.

SPHINCTER IMPAIRMENT

Examination of the rectum of the neurologically impaired patient with severe constipation or fecal incontinence may reveal lax sphincter tone or a perianal sensory stimulus may fail to produce a "wink" of the anal sphincter. These objective signs would not be found in the patient with psychogenic dysfunction. The presence of a bulbocavernosus reflex (contraction of the anal sphincter induced by a squeeze of the glans penis) provides evidence of the integrity of the sacral reflex arc. With urinary retention, a cystometrogram can be employed to evaluate the voiding reflex, but following prolonged dilatation of the bladder, or in the presence of infection, the data often are confusing. Thus, the amytal test (*vide infra*) is often helpful in the diagnosis of urinary retention of psychogenic origin.

SENSORY LOSS

In neurologic practice one not infrequently encounters unusual patterns of sensory alteration that fail to conform to known neuroanatomic distribution—radicular, peripheral nerve, and the like. The failure to perceive a tuning fork on one side of the skull, sternum, and vertebral spinous process, or a dense sensory loss to all modalities in one extremity that normalizes abruptly at the shoulder or groin does not occur with organic pathology. However, other patterns of sensory loss are less readily identified as psychogenic. Some patients with known organic pathology insist that altered sensation returns to normal at the midline, and not a few millimeters to one side as one anticipates on the basis of known patterns of pain fiber innervation. Even the tendency of psychogenic sensory loss to vary from day to day and examination to examination is duplicated by organic pathology.

Since sensation is an entirely subjective phenomenon, one might question whether there are any objective signs to which one can turn in doubtful cases. While it is perfectly true that any organic sensory loss can be duplicated in patients with psychogenic sensory disturbances, there are certain abnormal patterns quite typical of neurologic illness. For example, lesions of the brain stem and spinal cord which involve the lateral spinothalamic pathway and spare the dorsal column/medial lemniscus pathway create a so-called dissociated sensory loss in which an abnormality of pain and temperature sensation occurs with normal position and vibration sensation. Such an abnormality should be accepted in nearly every instance as *bona fide*. (Patients would not be expected to know that pain and temperature are more often affected together than pain and vibration). Similarly, sensory impairment that becomes progressively worse in the distal portions of the extremities ("stocking/glove pattern") reflects disease of the peripheral nerve and is almost always organic in origin. As in the motor examination, the finding of abnormal patterns typical of neurologic disease is more helpful than the opposite—that is, the finding of apparent abnormalities with which the examiner is unfamiliar or which he fails to understand.

MEMORY LOSS

Recent memory is always more affected than remote memory in organic memory loss, regardless of the pathologic process. In addition, organically impaired patients show not only a retrograde amnesia, but an anterograde disturbance as well, that is, difficulty in learning. This can be tested by

asking the patient to recall three unrelated objects after five minutes. Psychogenic amnesia is thus not usually difficult to distinguish from organic amnesia. For example, patients may claim to have forgotten their name, which is never an organic complaint in the presence of preserved language function.

Patients with impaired memory are usually unaware of the disorder and it is a relative or friend who makes the physician aware of the problem. The patient who complains himself of poor memory is most often found to have impaired concentration (due to a depression or financial worries, for example) that distracts him during his daily activities and thus mimics a memory disturbance. Recent memory testing of the latter patient under circumstances that achieve adequate patient cooperation will reveal adequate memory function.

SEIZURES AND SYNCOPAL EPISODES

This area is perhaps the most vexing, even to experienced clinicians. The reason is that the doctor rarely has an opportunity to see the episodes but is dependent on the description of others. In addition features of an organic seizure can be duplicated volitionally. It is not uncommon in practice to encounter patients who quite clearly have had major convulsions at some time in the past, but who now have frequent brief episodes of altered environmental awareness which resemble psychomotor seizures and are unresponsive to therapeutic doses of several anticonvulsant medications. At times, one has the impression that such patients are excessively introspective and misinterpret normal biological phenomena. The electroencephalogram is rarely helpful to the clinician in this situation, for a normal record does not exclude a convulsive disorder and a grossly abnormal record does not indicate that the patient's current episodes are part of the known convulsive disorder. Indeed, psychiatric disorders and temporal lobe epilepsy frequently are conjoined. In tertiary care facilities where telemetry is available, prolonged recording with the controlled administration of substances known to lower the seizure threshold may be justified. Because many individuals have witnessed convulsions, if only on television, a functional seizure may be strikingly organic in appearance. Physicians who treat such patients in a community hospital may, at times, be justified in administration of a placebo injection of saline to suggestible subjects in an attempt to witness an episode oneself. The patient is told that the injection is a "provocative test" and may cause a spell to occur.

ANCILLARY DIAGNOSTIC STUDIES

Because it is often difficult, even for seasoned clinicians, to decide about the "organicity" of a patient's complaint, certain ancillary diagnostic studies may prove helpful. The list of such tests is as long as the signs which patients may demonstrate, but a few of the more generally applicable ones are occasionally diagnostic.

1. *The Amytal® Test*³—Popularized in the lay press as "truth serum," this test relies upon the basic physiological principle that, in the presence of a toxic encephalopathy, functional impairments may improve, whereas organic impairments will worsen. One typically administers some 250 to 500 mg. of amobarbital (Amytal®) slowly by the intravenous route until the patient shows slurred speech and coarse nystagmus on horizontal gaze. There is nothing specific about this test, however, and any toxic substance that induces a state of intoxication ("drunkenness") may be ex-

pected to have similar effects. Indeed, when hospitalized patients are premedicated for a surgical procedure, one can repeat the pertinent aspects of the neurological examination often to great advantage. For example, following normal cystometrograms in the case of patients with unexplained urinary retention, where a functional etiology is suspected, one asks the urologist to leave the patient with a moderately full bladder at the end of the procedure. It is not at all unusual to find that patients with psychogenic retention will void in the "twilight" postoperative period. However, if voiding pain is a factor, one must interpret the results with caution because narcotics are frequently included in preoperative medication regimes.

2. *Electromyography (EMG)* The purpose of this test for the evaluation of the group of patients considered in this analysis is to document objectively the presence of denervation, a myopathy, disturbed neuromuscular transmission, or some other neuromuscular disorder. A careful EMG can often detect objective signs that the referring physician cannot see. There are, however, highly subjective features of EMG testing, and the electromyographer must be experienced in the evaluation of patients with psychogenic problems. As in other tests, a negative result is much less helpful than one which documents objectively the presence of disturbed function. Furthermore, it is not at all unusual to find that unsophisticated patients with psychogenic weakness report improvement following this test.

PSYCHIATRIC CONSULTATION

As a group, psychiatrists are aware far more acutely than primary care physicians of the inability, through interview techniques, to determine which impairments are organic and which are psychogenic. A past history of similar episodes can be helpful or dangerously misleading. Similarly, significant emotional events in the patient's current life do not mitigate against an unrelated organic neurologic problem. Only a careful neurologic examination can resolve the dilemma.

SUMMARY

Because the differentiation of psychogenic impairment of strength, sensation, and other neurologic functions from

organic dysfunction of the nervous system is often difficult, a collection of specific "tests" and "signs" traditionally have been thought to be the most effective way to make a diagnosis. Such signs and tests indicate an unequivocal psychologic origin of dysfunction in only a small fraction of the many cases encountered regularly by physicians in office practice. The daily menu of neurologic signs for public consumption in medical columns of newspapers, television programs, and the like has made our patients generally more sophisticated than appears to have been the case when these signs were originally thought to be of great value.

In the majority of such cases, only a carefully performed neurologic examination is likely to be diagnostic. The physician must search for such objective signs of dysfunction that are outside volitional control as changes in tone and reflexes. When that is not possible, the pattern of abnormality shown by the patient must be compared with that of known neurologic illnesses. A stocking/glove sensory loss in peripheral neuropathy, or impairment of recent memory with preservation of remote memory are examples.

When the results of the clinical examination are inconclusive, tests such as electromyography and the Amytal[®] test may be helpful. Finally, the phenomenon of rapid and spontaneous resolution of neurologic signs following hospitalization or a test such as electromyography, in a manner not known to occur with organic dysfunction, may indicate a retrospective diagnosis. The physician who undertakes the neurologic examination and its interpretation within the conceptual framework outlined above will make a correct diagnosis in most cases. Even more significantly, he will know why he is unsure of a diagnosis he has considered in a certain case and what steps to take to substantiate or refute his original impression.

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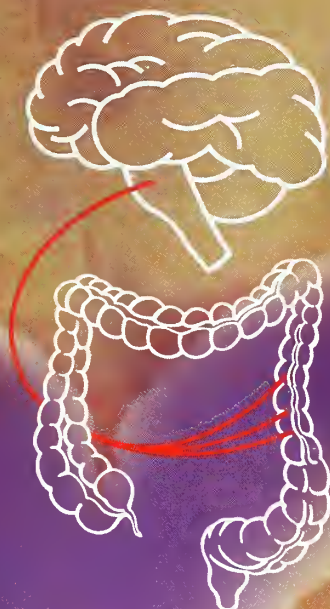
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Psychiatric Functions in a Forensic Unit

HAROLD S. FELDMAN, M.D., Ph.D., Newark*

A forensic psychiatric unit was dedicated at the Essex County Jail on May 1, 1976 by the New Jersey Medical School. This unit has become multifunctional: evaluation of criminal offenders for court hearings on competency; instruction of psychiatric residents and medical students; psychiatric treatment of criminal offenders; family consultation; social services; and so on.

Previous to the academic year of 1974-75, the New Jersey Medical School and its Department of Psychiatry and Mental Health Science, together with Martland Medical Center in Newark, were faced with a serious in-patient clinical problem. The enigma pertained to criminal offenders who were remanded to Martland Hospital by Essex County Superior and Municipal Courts for psychiatric evaluations attributable to defending attorneys' pleas of "temporary or permanent insanity" within the framework of "due process of law." This type of psychiatric patient created a formidable issue for the psychiatrists and staff on the in-patient service as well as non-offender patients assigned to the hospital's 10th floor.

THE PROBLEM

As a rule, twelve to fifteen or more criminal offenders were examined in a two- to four-week period during which time certain potential dangers were present and bed space for community patients was diminished. The risks centered around escape attempts by the offender patients who were guarded by armed correction officers on a 24-hour round-the-clock basis. In the past, several hospital employees have been killed or injured by escaping hospitalized offender-patients who had successfully wrestled service revolvers from correction personnel assigned to the psychiatric ward by the sheriff's office or courts. To offset these perils, a member of the New Jersey Medical School's Department of Psychiatry

(the author) was assigned the task of establishing an in-patient service unit for criminal offenders requiring psychiatric examinations outside the medical school hospital's facilities. After many attempts to perform such examinations of criminal offenders under adverse conditions in cell blocks of police headquarters, precincts, and municipal courts, a program for these patients was formed at the Essex County Jail with the approval of the jail's warden, the county judges, and sheriff, as well as the necessary administrative personnel of the New Jersey Medical School (1975).

THE PROGRAM

Initially, the program fulfilled requests of the Newark Municipal Court judges for psychiatric examinations on all criminal offenders who were suspected to be mentally ill. Referrals of this kind were no longer sent to the Martland Medical Center, thus removing risks of dangerous assaults by these patients and relinquishing psychiatric beds to more needy non-offender patients. The space provided by the jail's warden for these psychiatric evaluations consisted of a large reception room and three offices, located on the first floor of the jail, bounded by the "processing" rooms and legal counsel workplaces.

Examinations also were performed in the hospital and

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detention areas located on the 12th floor on inmates who were markedly agitated and disturbed.

Due to the increasing and variable workload, the likelihood of a forensic psychiatric teaching unit was proposed by the Chairman of the New Jersey Medical School's Department of Psychiatry for this facility. This was developed by the writer, and on May 1, 1976, with the sanction of Warden Albert T. Collier, the unit was dedicated as the Claudewell S. Thomas Forensic Unit. Since then, one, two, three or more psychiatric residents rotate through the forensic unit depending on availability and need. These residents interview criminal offenders and attend cases and hearings in court related to competency pleas and insanity trials. Also, they assist probation and parole officers in pre-sentence workups that require psychiatric evaluation and guidance.

The forensic unit recently has acquired a social worker who is likewise a correction officer. She is developing closer relationships between unit patients and their families as social histories are formulated by her for use in the forensic unit.

In addition to the court evaluations of the criminal offenders, psychiatric care has been extended to disturbed inmates. They are treated selectively by psychopharmaceuticals, psychotherapy counseling, and family therapy.

Recently, because of some success in the management of these patients, the administrators of the jail designated 26 cells on the tenth floor as housing for only psychiatrically ill offenders. Here these inmates are examined and treated on a daily basis during rounds made by the forensic psychiatrist and his staff. This Forensic Psychiatric Care facility, as it is now called, is part of the forensic Psychiatric Unit and relates also to the Martland Hospital in-patient Forensic Team. The latter attends non-offender patients hospitalized on the psychiatric wards who have had emotional behavioral difficulties with the law enforcement agencies of the community. This team's position is that the prevention of recidivism and probable successful rehabilitation of forensic psychiatric patients can be attained to some degree by the forensic psychiatric coordinate approach.

THE FORENSIC PSYCHIATRIC PATIENT AND TEAM

A forensic psychiatric patient may be defined as an individual who has become enmeshed with the law as a criminal offender, a convicted person, a parolee or a released convict because of mental illness, personality deviation or both. An ideal in-patient forensic psychiatric team may consist of a psychiatrist (Chief of Forensic Unit, N.J.M.S.), a psychologist, a social worker, one or more psychiatric residents, the psychiatric nurse, one or more rotating medical students, and other parapsychiatric personnel when needed. As previously stated, criminal offenders who are mentally disturbed are under the care of the Forensic Unit staff while incarcerated at the Essex County Jail. These persons cannot leave the jail while awaiting trial, unless they are placed under armed guard. For the reasons set forth above, in-patient hospitalization and treatment is difficult and dangerous unless their court detainers are dropped and they then are committed to county and state mental hospitals or voluntarily enter city hospitals without armed correction officer escorts. This is now done at Martland Medical Center.

In addition to the patients whose charges have been dropped, parolees, criminal offenders on bail programs, and released convicts who have returned to their communities are appropriate patients for therapy by the Forensic Team.

The Forensic Unit at the Essex County Jail is a sizable patient referral source for the in-service forensic group. All the psychiatric modalities, including psychotherapy, psychopharmacology, counseling, and family therapy are employed by the team in attempts to modify or prevent delinquency, criminal behavior, and recidivism. Patients admitted to the in-patient psychiatric service of Martland Medical Center who have a forensic background or history are referred by the Chief and Deputy Chief of the psychiatric service to the Forensic Team, and the forensic psychiatrist directs the therapy of these patients aided by team personnel. Case conferences on forensic psychiatric patients are held with the residents on the forensic service and other team members. Residents and medical students serving in the forensic unit and team have an advantage of involving themselves with forensic patients under different kinds of settings. Other forensic psychiatrists who serve on the clinical staff of the Department of Psychiatry and Mental Health Science participate in rounds and case presentations with the residents, medical students, and forensic team.

Law students from local law schools have joined the forensic team, on occasion, on rounds and case discussions to further mutual comprehension of forensic psychiatric problems arising in medical and legal practices.

The Forensic Unit and Team function together as a clinical effort in rendering valuable community psychiatric care to neurotic, psychotic, and deviant behavioral patients who are all involved with forensic problems.

During the past year, 900 to 1200 such patients have been served by the forensic unit and team. In addition, 25 to 30 criminal offenders are evaluated each month for the Municipal and Superior courts and eight to ten disturbed offenders are committed from the unit during a thirty-day period. The educational program of the Department of Psychiatry and Mental Health Science has accepted the Forensic Unit as an instructional facility. The unit teaches residents and medical students the basic principles of forensic psychiatry and the application of these techniques to the psychiatric patient and his relationship to the law. Its educational procedures are as follows:

(a) One, two or three psychiatric residents are assigned by the chief of the department's residency training program for three or four months rotation on the unit. They serve a total of six to ten hours a week.

(b) Medical students are assigned as: (1) first or second year students in summer research fellowship programs for a five to six-week period, working daily from 8:30 a.m. to 3:30 p.m., five days a week on a selected research project. (2) fourth year students in an elective program of four weeks, serve the unit, daily 8:30 a.m. to 4:00 p.m., five days a week. (3) third year medical students in groups of six to eight are assigned to the forensic team in the Martland Medical Center on the wards as they rotate through the psychiatric service. (4) second year medical students meet in a group of eight each Wednesday morning for an eight-week period from 9:00 a.m. to 12:00 p.m., developing their interviewing techniques with forensic patients.

In conclusion, it is important to note that the psychiatric functions of a forensic unit offer unique psychiatric services to the community and significant adjunctive educational features to students of medicine and psychiatry.

SUMMARY

A Forensic Psychiatric Unit should be an integral part of departments of psychiatry because the functions of such a

unit serve the community and the teaching programs of the medical school.

Primary psychiatric functions of a Forensic Unit are:

1. Determination of competency of criminal offenders for trial by Municipal and Superior Courts.
2. Commitments to county or state hospitals of dangerous criminal offenders awaiting trial, who are homicidal or suicidal.
3. In-patient psychiatric service to criminal offenders who are confined in the jail's hospital, detention cells, and forensic

psychiatric care facility.

4. Training of residents and medical students in forensic psychiatry.
5. Psychiatric consultations to courts, probation, and parole officers.
6. Educational meetings with correction officers and other law enforcement personnel.
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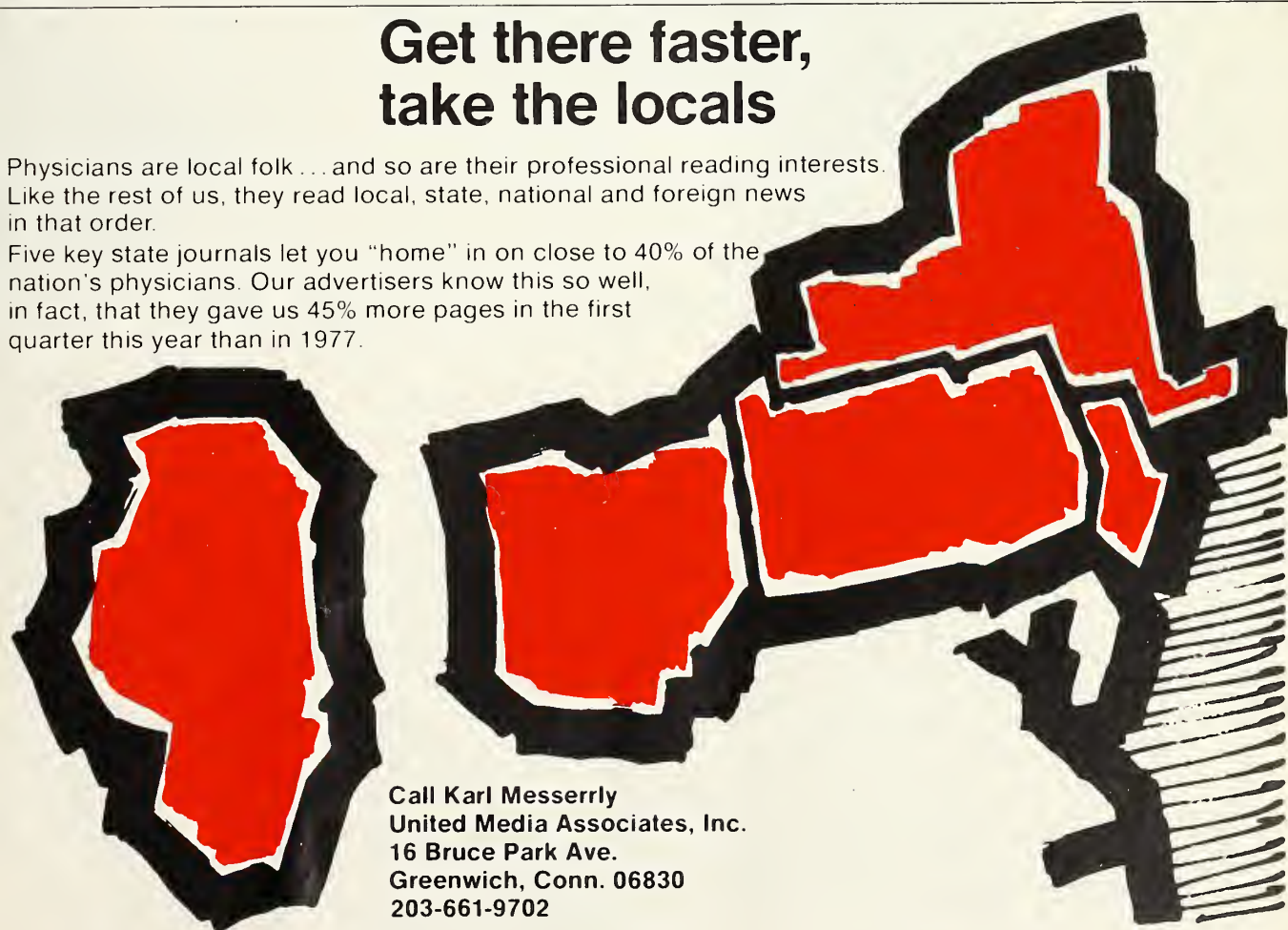
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Assessment of the Internist's Competency*

WILLIAM C. FELCH, M.D.
Rye, New York

Competency assessment of specialists in internal medicine is not easy. The reasons include the depth and breadth of the internist's information pool—his skills are difficult to measure, his performance is often intellectual rather than technical, and the outcome of his continuing care may not be clear cut.

Competency—or competence—is a hard word to define. Yet we all know what we mean when we say “He—or she—is a good doctor.” If pressed to explain what we mean, we will use such phrases as “He knows his game” or “He handles his patients very well” or “His patients turn out well.”

Unconsciously, in using these phrases, we are assessing his competency. Saying “He knows his game” means that we believe he has an up-to-date fund of knowledge about internal medicine, particularly those aspects that he faces regularly in practice. But “knowing the game” is not just a matter of knowledge, of information retention; it also means possessing certain skills (data collecting skills, interpersonal skills, procedural skills) and certain attitudes (of caring and concern, of conscientiousness and dependability).

When we use the phrase “He handles his patients well,” we have shifted from his capabilities—the tools he brings to his tasks—to his performance: how he actually behaves on the firing line, how skillfully he takes a history, conducts a physical examination, makes a diagnosis, orders treatment.

And when we say “His patients turn out well” we are awarding him the ultimate praise: the outcome of his capabilities and of his performance is beneficial to patients.

How do we go about testing for these qualities? It would be ideal if we could look at patient outcomes and relate them back to the physician's capability and performance; but it is hard to get a handle on long-term outcomes and short-term indicators may be inappropriate.

Another way—one for which the American Society of Internal Medicine (ASIM) currently is involved in research studies—is to assess physician performance in the real world by an audit method, comparing actual behavior with pre-set

criteria.

The most familiar and traditional way is to test knowledge, as is done in the American College of Physicians (ACP), and the American Board of Internal Medicine (ABIM) certification and recertification examinations. Even though knowledge is only one element of physician capability and even though the possession of knowledge by no means guarantees good performance or good patient outcomes, still the possession of up-to-date information is the *sine qua non* of the competent physician.

Thus far I have discussed physicians in general. Is there anything unique about competency assessment of internists? I think so. First, I would argue that the internist requires a greater depth and breadth of information than other practitioners, simply because internal medicine encompasses more. Second, the internist's skills are not the easily measured motor-manual skills of the surgeon; internists must deal competently with interpersonal and human factors instead. Third, our performance is often an intellectual one—and while perhaps its rational and logical processes can be assessed, there is much that is intuitive about it. Finally, our care is often the continuing care of chronically ill patients and their outcomes are most difficult to sort out. Still, for many reasons, we must continue to try to figure out ways and means of assessing our competence. The distinguished members of our panel will tell us why and how.

*Presented before the 10th annual combined regional meeting of the New Jersey Society of Internal Medicine and the New Jersey Chapter of the American College of Physicians, November 9, 1977. Dr. Felch was Medical Director, United Hospital, Port Chester, New York, and Past-President, American Society of Internal Medicine. He may be addressed at 269 Purchase Street, Rye, New York 10580.

Public Accountability and Quality Protection*

ANNE R. SOMERS, D.Sc., Piscataway

Meaningful public accountability in the health field involves a set of commitments, institutions, and procedures. The essentials of quality assurance include professional education and credentialling, a good doctor-patient relationship, continuous monitoring, and corrective action when necessary.

Two hundred years ago the Founding Fathers wrote into the U.S. Constitution civilian control of the military, anticipating by more than a century the famous aphorism attributed to the French statesman, Georges Clemenceau, "War is too important to leave to the generals."

Today, more and more Americans seem to be saying, "Medicine is too important to leave to the doctors." Note that I say "medicine" not "health." To say "Health is too important to leave to the doctors" would be equivalent to saying "Peace is too important to leave to the generals." The real meaning would be lost. "Peace" and "health" are universal goals that everyone can agree on—as "motherhood" used to be. But "war" and "medicine" are instrumentalities involving vast resources and the power of life and death. These are the provinces of the experts, the professionals, where laymen are rarely welcome, and where real-life policies often evolve more in relation to immediate professional needs and prerogatives than to long-run public goals.

On June 3, 1976, *The Evening Times* of Trenton, New Jersey carried as a first page, six-column headline—an honor usually reserved for presidential elections or declarations of war—the following banner, "Estrogen linked to uterine cancer increase." The Associated Press story that followed was based on two articles that had appeared in the *New England Journal of Medicine* of the same date. Presumably the story was carried in hundreds of papers using AP wire services throughout the country.

The reason for this tremendous public interest in a highly technical medical subject is obvious: Millions of American women are, or have been, taking post-menopausal estrogen and thus feel their lives threatened. The impact of such public interest and public concern on the practice of medicine is very great, especially in ambulatory care where consumers feel a little more confident or, perhaps, less intimidated than they do once admitted to a hospital bed. As to whether this impact is positive or negative, there is considerable disagreement among physicians, just as there is disagreement in the military as to whether civilian "interference" is a good thing or not.

I welcome this development as a sign of increasing public knowledge or at least the desire for knowledge. Moreover, I believe this incident is symbolic of what is happening to medicine generally: The public is beginning to demand "accountability," not only in terms of professional integrity and fiscal responsibility, but in the quality and appropriateness of the care it is receiving.

To a profession long accustomed to operating in a context of professional privilege and almost unquestioned authority, adjustment to the frequently harsh and, sometimes, unfair

*Presented before the 10th annual combined regional meeting of the New Jersey Society of Internal Medicine and the New Jersey Chapter of the American College of Physicians, November 9, 1977. Dr. Somers is Professor, Department of Community Medicine and Department of Family Medicine, Rutgers Medical School, CMDNJ. She may be addressed at the School, University Heights, Piscataway 08854.

glare of the public limelight is bound to be difficult and, at times, traumatic. The results, as the recent malpractice crisis indicates, are not always positive, either for the profession or the public. Nevertheless, I believe this is a development implicit in our historic commitments to universal education and universal suffrage and that the final results can be both significant and constructive if the leadership of both the profession and the public is willing to work hard enough and make the necessary adjustments.

In this presentation I would like to raise some of the issues involved in the two concepts that make up the title of my talk—public accountability and quality protection.

PUBLIC ACCOUNTABILITY IN THE HEALTH FIELD

The concept of “public accountability” involves, in my view, two essential ingredients: (1) genuine participation by private sector professions and institutions in the formulation of public goals, and (2) a commitment to work toward such goals in a fiduciary or stewardship role, including an ongoing “accounting” to the public for this stewardship.

Stated a little differently, the concept not only presupposes continued existence of the private sector, but a large degree of professional and institutional independence. The opposite side of the coin is that the professions and the institutions may expect to retain their private status only so long as they act as if they were public.

This may seem a meaningless distinction but, to me, it seems very important. If we, in America, can achieve a combination of public goalsetting and private sector implementation, avoiding the evils of over-centralization and over-bureaucratization implicit in too much direct government control, we will have made a major contribution to the development of democratic self-government.

“Public accountability” might be likened to the “categorical imperative” propounded some 200 years ago by Immanuel Kant. At a time when philosophers were hotly debating the existence of God and the relevance of competing ethical principles, Kant concluded that, while His existence could not be proved, it behooved the individual to conduct himself *als ob* or “as if” the universe were ordered in accordance with universally binding moral law.

The concept is particularly relevant and useful in the health field. Considerations of professional responsibility and public trust are imbedded deeply in the health professions and in hospital history. They are implicit in the Oath of Hippocrates and explicit in the state licensing laws.

It is obvious that the government cannot take over and run the nation’s health care system or even a single hospital without the cooperation of the majority of professionals involved. It is equally obvious, in this day of multi-billion dollar health care costs, that the private professions and institutions cannot function effectively without government participation and without implied acceptance of publicly-defined goals.

For various reasons, consumerism and public accountability were slower in emerging in the health field than in some others. Among these, were the atypical role of the health care consumer, the persistence of the “medical mystique,” and the traditional sharp distinction between the public and private sectors in the health care economy, with public involvement and surveillance almost exclusively concentrated in the public sector. Most of these conditions are changing and pressures for “public” or “consumer” or “patient” involvement are building up rapidly.

Despite lingering resistance—some of it very strong—many health care institutions and agencies are trying to respond to these pressures in a positive fashion.

One of the first examples of what we now call public accountability was the program of the American College of Surgeons which eventually led to the Joint Commission on Hospital Accreditation. More recently, the commitments and activities of a number of foundations for medical care and prepaid group practice plans fall under this rubric.

I would so classify the efforts on the part of many Blue Cross and Blue Shield plans to increase public or consumer representation on their boards. And the move on the part of some hospitals to set up “ombudsmen,” “patient representatives,” or “consumer advisory committees.” And the American Hospital Association’s effort—not highly successful but still significant—to develop a uniform Patient’s Bill of Rights. Indeed, this movement has reached the point in the hospital field that a Society of Patient Representatives has been established within the AHA.

PSRO is, of course, the most far-reaching example to date. It is still far from clear what direction PSRO’s will take in the future—whether government will move in with too heavy a hand and turn public accountability into bureaucratic and counterproductive regulation, whether the profession will try to convert PSRO’s into very expensive fig leaves for non-accountability; or whether a genuine and intelligent cooperative effort on the part of government and the profession will permit them to achieve their full potential as instruments of public accountability. But the potential is definitely there and should be welcomed by all who cherish the continued independence of the medical profession.

I suggest that under present conditions—with U.S. health care costs now running over \$150 billion a year (more than the entire GNP of all but a handful of nations) and again in the vanguard of national inflation; in the absence of competitive pricing, advertising, and other attributes of the “free market,” and with continuing pressures for ever-tighter government controls—the future of the private sector well may depend on its willingness and ability to observe this new “categorical imperative.” That is, to act “as if” it were a public rather than a private enterprise and to accept the public’s own definition of the “public interest.”

At this point, however, public accountability becomes more than an idealistic slogan. It has to be given substantive content and definition. And so, for the sake of discussion and debate, I suggest the following summary statement: *Meaningful public accountability in the health field involves a set of commitments, institutions, and procedures which will promote the reconciliation of private ownership, private operation, and professional independence with public goals and public standards of integrity, quality, and financial responsibility.*

In keeping with the theme of this meeting, the rest of my remarks will be concerned with quality only. But it must be kept in mind that it is impossible to separate completely quality from either professional integrity or costs.

Without going into any of the technical aspects of quality controls, I would like to conclude by identifying four aspects of quality which I believe the public-at-large and individual consumer-patients share.

FOUR ESSENTIAL ASPECTS OF QUALITY ASSURANCE

1. **Professional education and credentialing.** Technical competence is, of course, the *sine qua non*. It is what makes a

doctor a doctor. It is the characteristic which the public simply would like to take for granted. It is prepared, even anxious, to leave the education and credentialing of physicians to the profession itself and is prepared to support such education and training generously. It only asks that you do a conscientious job.

Has the profession met the public's expectations with respect to technical competence? Obviously, not in all cases, but I would think that, on balance, the answer has to be "Yes." U.S. medical education in the technical sense, both undergraduate and graduate, is almost certainly better than it ever has been, despite the pressures for rapid expansion and for a student body more representative of the total population. Certifying examinations for medical specialists are more rigorous than ever before.

The two big issues in this area involve (a) the qualifications of the foreign medical graduate now that nearly half of all new licentiates each year are foreign-educated; and (b) the question of re-licensure and/or recertification. It is a pleasure to be able to congratulate the American Society of Internal Medicine, the American College of Physicians, and the American Board of Internal Medicine for their stand on recertification, just as I long have congratulated the American Academy and the American Board of Family Practice for their pioneer stand on this question. Both of these are issues that deserve serious and prompt attention to round out the profession's generally good record with respect to technical competence.

2. A good doctor-patient relationship. I place technical competence before the doctor-patient relationship because, if I, as a patient, had to make a choice, this would be my order of priority. Millions of Americans feel differently, however, and, when forced to choose, select the doctor who, they feel, takes a personal interest in them. Without question, the public believes that this is an essential aspect of quality medical care. And this is an aspect where, it is also widely believed, the profession is deficient.

The reasons for this deficiency are, in part, overloaded practices, in part, the same as those that have led to the increase in technical competence. As emphasis on the "science of medicine" has increased, there has been less and less attention, either at the undergraduate or graduate level, to the "art of medicine," including patient education, patient management, and health maintenance.

To some extent this has been compensated for by increasing emphasis on the behavioral sciences in medical school curricula. But a more scientific approach to the neurotic housewife, the middle-aged alcoholic, or the general field of behavior modification—important as these new professional concerns may be—is not what the public is talking about. What it is talking about is a doctor who really cares for his patients, who sees them as individual human beings, and is prepared to take time to help them formulate and then achieve their own health goals.

Whether this is too much to expect of a doctor, today, is perhaps debatable; but the fact that the public wants it is not. And if the medical profession has decided that it cannot provide this kind of care to 215 million people, then it should say so and help to develop alternative sources for this human relationship that most people both want and need so badly.

Doctor Edmund Pellegrino, Chairman, Yale-New Haven Medical Center, a student of this subject, has suggested that primary or ambulatory care should be delivered by primary care teams, including a physician, a nurse clinician, and a nurse educator or "health practitioner." The latter, working

under the supervision of the doctor, presumably would have more time to relate personally to the patient. In one way or another, this question will have to be addressed if the public ever is to be satisfied with its ambulatory care. If, as I suspect, the answer does involve some sort of team approach, then this fact should begin to be reflected in medical education, in quality criteria, and in review procedures.

3. Institutions and procedures for continuous monitoring. Recognition of the desirability of some sort of peer review or professional self-discipline goes back at least half a century to the time, already noted, when the American College of Surgeons first began to call for review of hospital surgery. We have moved a long way since those days, through the era dominated by the Joint Commission on Hospital Accreditation, to the present PSRO period. We still have quite a way to go, however, before either the profession or the public can be satisfied that the generally high technical standards established in medical school are observed throughout a lifetime of practice.

Incompetence never can be eliminated completely. Doctors are human beings and human beings get older, get tired, get distracted, and make mistakes. Most patients are prepared to accept some degree of honest error, even from their own doctors and involving their own bodies. Here again the degree of tolerance has a lot to do with the nature of the doctor-patient relationship.

But beyond this zone of tolerance, there is now a rapidly growing conviction that the profession, both academic and practitioners, should match the constant talk of "quality medicine" and its inevitably high cost with more effective institutions and procedures to make sure that such quality medicine is actually getting to all patients. It is disappointing that, five years after the PSRO law was enacted, only a little over half of the 203 designated PSRO areas are even "conditional."

At the moment, there is less pressure for monitoring at the ambulatory level than in the hospital. The primary care physician is less likely to make an irreversible goof than his colleague in the operating room. But when we consider that most chronic illness is cared for on an ambulatory basis, that most initial diagnoses are made on this basis, that most medications are prescribed, rightly or wrongly, on this basis, the opportunity for error—even on the part of well-trained and well-motivated physicians—and the need for monitoring ambulatory as well as inpatient care become obvious.

The technical problems of peer review are receiving increasing attention from the profession. This is essential. At the same time, I hope you will not lose sight of the equally important problem that might be identified as the "politics of peer review." Who will do the monitoring? What institution(s) will be responsible?

If these questions were difficult in the hospital setting, they will be even more so in ambulatory care. Institutions such as ACP and ASIM, that stand at the interface of public goals and professional expertise inevitably are caught in a current no-man's-land—the target of criticism from traditionalists in both camps. But it is also an important, perhaps history-making, opportunity with far-reaching implications, not just for health but for American society as a whole.

4. Corrective action when necessary. This is the fourth and last aspect of "quality protection" that I want to stress, the ultimate test of the profession's seriousness in assuming stewardship for quality care on behalf of the public.

It has been said that with all physicians well-trained, periodically re-examined and recertified, operating under a

system of peer review or collegial monitoring, there should be very little incompetent care. Hopefully, this will be the case. The effectiveness of the monitoring, however, and to some extent continued improvement in medical education may depend on the seriousness with which the profession undertakes corrective action when necessary. Whether this action takes the form of mandatory continuing education, restriction or removal of hospital privileges, or the ultimate—revocation of license—is for the profession itself to decide.

The public may not be quite as vindictive as the emperor in *The Mikado* with his determination “to make the punishment fit the crime” although the attitude of some juries suggests that we are moving in that direction. Once again, it would appear that professionally administered “corrective

action” is much to be preferred from everyone’s point of view.

In conclusion, let me congratulate the American College of Physicians and the New Jersey Society of Internal Medicine for their work on behalf of quality assurance. By acknowledging the interrelationship of public goals and professional standards, you are serving both the public and the medical profession. It will not be an easy task. The stakes are high. The price of failure could be loss of autonomy for the profession. But success, if combined with universal access to essential health service and effective cost containment, could mark the beginning of a whole new and exciting chapter in the history of American medicine.

DESCRIPTION: Methyltestosterone is 17 β -Hydroxy-17-Methylandroster-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunuchism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric,

avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE**

REACTIONS: Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg. Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchidism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahoglu, M.D.: Hormones for Improved Sexuality in the Male and the Female Climacteric. *Drug Therapy*, Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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Assessment of Clinical Competence by Certification*

GEORGE D. WEBSTER, M.D., Philadelphia

The process of certification and recertification is one method of assessment of clinical competence. However, measurement of performance requires much research and evaluation.

Clinical competence is relatively easy to define in general terms. An acceptable definition would be that clinical competence is the ability to utilize medical knowledge to produce the optimal solutions to medical problems. However, as one attempts to become more explicit, it becomes more and more difficult and subjective. Yet, the specialty boards have assumed the responsibility for assessing clinical competence of physicians for 40 years. Because of the difficulty of definition the evaluation methods have developed intuitively and differ from Board to Board. I will be discussing only the certification process of the American Board of Internal Medicine (ABIM).

PROCESS

I wish to emphasize the use of the word *process*. It is very easy to think about certification only in terms of the final traumatic hurdle we have been forced to jump, but from the outset the certification process has consisted of three distinct steps, each of which is considered essential. The first of these steps is the completion of a prescribed training program. The Board specifies the duration and, to some extent, the content of the training and requires that it be undertaken within an approved training program. It participates with the American College of Physicians and the AMA in the accreditation of these training programs. Educational psychologists state that, if we can define explicitly and in sufficient detail all of the components of clinical competence and also

devise valid measures of each of these components, the duration of training would not make any difference. However, we lack that precise definition and the Board feels strongly that time is essential for the seasoning, the maturation, and the development of the clinical judgment of the internist. Therefore it recently restated with increased firmness that three years of training in general internal medicine is required, and that 24 months of this period shall be in an environment in which the resident can assume increasing responsibility for direct patient care.

The second component of the certification process is the assessment of the clinical skills. These include such things as the ability to obtain a history, perform a physical examination, organize the information in a logical way, and develop a management plan. Since many of these things only can be assessed by observation of the physician, they have from the beginning been part of the certification process. Originally, assessment of these components was accomplished by the oral examination which required the candidate to examine two live patients and then present and discuss them with two Board examiners. In the 1960's, the Board undertook some studies to evaluate the oral examination and found that it

*Presented before the 10th annual combined regional meeting of the New Jersey Society of Internal Medicine and the New Jersey Chapter of the American College of Physicians, November 9, 1977. Dr. Webster is Director of Evaluation, American Board of Internal Medicine, Philadelphia. He may be addressed at 3930 Chestnut Street, Philadelphia 19104.

was not as reliable as was desired for making pass/fail decisions on candidates. The steps required to make it more reliable, namely an increase in the number of interactions, were thought not to be feasible, in part due to the decreasing availability of patients for these purposes, and because of the projected number of candidates in future years. Therefore, in 1970, the Board replaced the oral examination with its program of evaluation of clinical competence in which it has asked the training program directors to share with the Board responsibility for attesting that these clinical skills have been achieved. The Board specifies the skills it feels are important, develops assessment guidelines for program directors, and visits program sites, not to accredit them but to advise them on their evaluation procedures. It asks for a four-page evaluation of each applicant for admission to the written examination. If a program director and his evaluation committee have adjudged a candidate as less than satisfactory in these skills, admission to the written examination is denied.

The third stage in the certification process is the written examination to assess the breadth and depth of the candidate's knowledge and his ability to use that knowledge. It is a two-day written examination consisting of multiple choice questions and patient management problems.

Upon successful completion of these three hurdles, a candidate is then adjudged by the Board to "possess the knowledge, skills and attitudes essential to the provision of excellent care in internal medicine."

RECERTIFICATION

Certification, of course, does not guarantee that a physician will perform in this fashion but only that he has the ability to do so. It also does not guarantee that a physician will maintain that ability. Hence, the Board instituted a recertification program. The first recertification examination to be given by a specialty board was given by the ABIM in 1974 to 3,500 applicants. Since it was felt that the present state of the art of evaluation allows assessment only of knowledge and other intellectual abilities of the internist, it was a one-day multiple choice examination which was closely linked to the ACP's amazingly successful Medical Knowledge Self-Assessment Program (MKSAP). The second recertification examination was given two weeks ago and over 2,000 individuals took this exam. The format was expanded to include patient management problems and it again was linked closely to the ACP MKSA Program.

THE TASK FORCE

Out of the need to evaluate further whether the Board's certification process actually was assessing the important components of clinical competence, the Board, two years ago, assigned to a task force the job of explicitly defining the components of competence. Taking a lead from the American Board of Pediatrics, they developed a three-dimensional system for looking at clinical competence. The facets of this system include the *attitude* and the *abilities* required of the internist. Other dimensions describe the *tasks* an internist must perform in solving a medical problem, and the entire domain of the diseases or problems the internist sees.

Very briefly, the task force divided the abilities in the first dimension into four categories; namely, *habits or attitudes* the internist should have in approaching patients with medical problems; the *interpersonal skills* required to communicate with the patient, the patient's family, and other members of the health care team; the *motor skills* required, running the gamut from the basic skills essential to the physical examination to the more complex skills that might be re-

quired for certain diagnostic procedures; and the *intellectual abilities* demanded of the internist. The latter can be divided into a hierarchy of increasingly complex abilities running from the simplest, but very fundamental, ability to learn facts about the patient and about disease, to be able to recall these facts and utilize them in the solution of medical problems. Higher levels of intellectual ability include those that are required to organize facts into a logical pattern, to synthesize facts, to reach conclusions, and finally to exercise clinical judgment—that is to be able to weigh the facts and knowledge obtained in order to proceed in the most appropriate and optimal way.

The tasks required for medical problem solving can be broken down into several specified categories such as data gathering (through the medical interview, through the physical examination, through the performance of laboratory procedures, and so on) the definition of the nature of the problem or diagnosis, and the development of acute or chronic management.

Thus, utilizing this system, for any particular medical problem, it is possible to define explicitly and in considerable detail the performance characteristics required of the internist to perform specific tasks in the medical encounter.

The task force then analyzed the current certification process. What was found was, in some ways, reassuring. The questions in the multiple choice sections of the examination, when examined across the dimension of medical illness, seem to sample the domain reasonably appropriately; over 50 percent of the questions were deemed to be about medical problems that fit within the province of primary care. Examining the examination along the dimension of intellectual abilities, it was reassuring that the majority of the multiple choice questions and the patient management problems were asking for higher levels of intellectual ability such as synthesis and clinical judgment. Along the axis of problem-solving tasks, there appeared to be a good spread of questions except in the area of chronic management and health maintenance. On the other hand, there were very significant areas the task force and the Board felt were not being assessed adequately by current procedures. Strikingly absent were techniques to evaluate candidates' attitudes, interpersonal skills and motor skills. Some assessment is taking place in these areas by virtue of the assessment of clinical competence during training, but not in a structured way. As a result, the Board's Committee on Clinical Competence now has made it mandatory that the candidates be observed by faculty, at least once during the three-year period of training, obtaining a history and doing a physical examination. In addition, the Committee has been charged to develop guidelines for program directors for more explicit assessment of these abilities, to provide models of evaluation instruments such as rating scales or check lists. The Certifying Examination Committee has been asked to explore further the introduction of objective questions and possibly new question formats into the written examination that might provide measures of these abilities. Further, the Board has sponsored and supported two separate research projects involving computerized patient simulations which it hopes will, by virtue of an unclued interaction with standardized "patients" with predefined performance criteria, allow a more objective assessment of data-gathering skills and management. In January, it will undertake a national field test of one of these projects involving over 300 volunteers from the population that have just taken the 1977 Recertification Examination.

CONCLUSION

No matter how reliably and completely the Board in the future manages to assess the ability of the internist to provide excellent medical care, there is no assurance that this demonstrated ability necessarily is translated into an excellent outcome measured in terms of performance. Appropriate discussions have gone on in the American Society of Internal Medicine (ASIM) and in other arenas concerning the need for measurement of performance. While there has been very active investigation of the feasibility of such measures (e.g., chart audit) by the ASIM and many other organizations, it seems likely that, even if they can be demonstrated to be reliable, the process may be prohibitively expensive. The Board strongly supports such research

efforts. However, it feels that the future potential of performance measurements lies less in their widespread applicability than in their usefulness in the validation of other less expensive indirect measures of performance. If it can be demonstrated that a high level of performance correlates well with such measures as an objective written examination, written patient simulations, or more likely, computer simulations, these latter methodologies can be applied at much less cost to a much larger population and at more frequent intervals.

When and if that day comes, the Board will be able to say to the public, with more credibility than it can at the present time, that the certified internist not only is equipped to be clinically competent, but further, that he or she actually provides high-quality medical care.

Coping with Medical Obsolescence*

ARTHUR BERNSTEIN, M.D., East Orange

The evaluation of and solution to obsolescence of medical knowledge is complex. Evaluation of performance is the best measure of the physician's competence. Medical audit and PSRO offer an opportunity. In addition to CME, new methods of retraining include the sabbatical year residency and the mini-residency.

There are so many problems facing the practicing physician today that it is difficult to know where to turn first. However, the most important from the point of view of our profession is the question of obsolescence of knowledge and its effect on the practice of medicine.

PHYSICIANS' RECOGNITION AWARD

The American Medical Association has promoted one of the ways to overcome obsolescence, namely, the Physician's Recognition Award (PRA), which is based on continuing medical education using selected categories. This program has spawned an endless number of courses and journals with self-assessment examinations so that each physician could achieve his "brownie points." Has this any merit? Of course it has some.

There is no question that one must have basic knowledge in order to care for patients, but this is only half the picture. In an editorial Robert J. Levine points out that some of the best residents did not do well on National Board Examinations.¹ Many of our best bedside physicians have not done well on written examinations for diverse reasons. In 1956, Peterson *et al.* failed to show a correlation between continuing medical education and the quality of medical care given by a group of family physicians in North Carolina.² Lewis, *et al.* found similar results.³ This would indicate that continuing medical education by itself does not necessarily improve medical care. Knowledge and good medical care

are not synonymous. As Aring pointed out in a recent editorial: "To re-evaluate physicians with traditional national or specialty board examinations which assess memorized knowledge will not tell what they will do with patients. They may delineate a particular segment of the professions, but there is nothing that says that a scoundrel can't memorize. How a physician proceeds can be demonstrated by an audit of action that depends more on the proper discipline in approaching medical problems than on memory."⁴ However, monitoring this becomes an almost impossible task.

Does the PRA really do any good? After having spent a number of years as Chairman of the Committee on Medical Education of the Medical Society of New Jersey, I feel that it does, in spite of the negative reports that I have just quoted. It brings absentee physicians into courses, back into making hospital rounds and, most of all, it stimulates them into thinking, which is one of the major purposes of education. The taking of courses, the attendance at grand rounds, the reading of journals, and the listening to tapes are all of value, even if only subliminally.

*Presented before the 10th annual combined regional meeting of the New Jersey Society of Internal Medicine and the New Jersey Chapter of the American College of Physicians, November 9, 1977. This is a modified version of a commentary published in *J Med Soc NJ* 74:261-264, 1977. Dr. Bernstein now is Clinical Professor of Medicine, New Jersey College of Medicine and Dentistry, and Medical Director of Crossroads Health Plan, the Essex County HMO/IPA. He may be addressed at the Plan, 141 South Harrison Street, East Orange 07018.

RECERTIFICATION—RELICENSURE?

Is the recertification examination or the relicensure examination a better way to overcome medical obsolescence? Has this any unique merit? You have read Doctor Webster's opinion.^a Can obsolescence be measured by "re-examination" which measures only knowledge or should we use "competence in practice" which includes both knowledge and the art of medicine? The debate rages furiously with the "Boards" demanding re-examination for "knowledge" and the practicing physician shouting that "performance" is what counts. Many of us oppose the re-examinations but because of our own insecurities, we allow ourselves to be led like sheep down the path of least resistance called "multiple choice." Is reason being replaced by rationalization?

Government and other bureaucracies now use the specialty boards to measure competence in recruitment and promotion.⁵ The Board examinations do not measure the competence of the individual in the everyday care of patients. Knowledge does not measure the most important facet of practice—"performance."

No two people do well with the same type of examination. Some prefer true and false, others multiple choice and still others lean toward essay questions. Some fancy the computer type of examination and others "case management." It is next to impossible to find one technique that truly will evaluate all the takers. Therefore, to give one examination to all people and then grade them all on the same "bell-shaped curve" is unrealistic. This is fine for the beginning student whose young mind is a blank and can learn new things because it has no previous experience to disrupt the thought. However, this is not a good method for trained physicians, no two of whom have had the same experience. This is the difference between pedagogy and andragogy. Therefore, the same set of questions means different things to different people. Not even the teachers always agree on the answers.

In an editorial by Howard L. Horns⁶ in *JAMA* he made the point that the practice of medicine is varied and pluralistic in nature. Physicians are different in their methods and aptitudes for acquiring new knowledge. Physicians neither learn the same way nor think the same way, so it follows that they do not give the same answers in examination. Some have auditory, some visual, and some discussion-type learning aptitudes with totally different methods of applying this knowledge. We, therefore, must develop several methods of maintaining professional competence. We must make allowance for performance characteristics as well as knowledge and skills.

PERFORMANCE

In studying obsolescence, we must look at the other side of the coin—"performance." Excellent performance is the goal that the patient wants to see achieved. However, this is a difficult factor to measure as pointed out by Doctor Felch.^b Again, we must deal with the pluralistic nature of medical practice and patient care. The physician must know how to "lay on hands." He must understand the "art of medicine." The "bedside manner" is not a dead issue. At times it is more important to know how to talk to the dying patient than to identify the type of malignancy.

The term, "art of medicine," does not imply the old snake oil salesman. It is a truly demanding ability to recognize the needs of the patient. The physician must be able to respond to the patient's needs by switching roles to "father," "friend," "brother," "sister," or "teacher," but never to

"judge." He must show interest and concern so that the patient will accept his scientific knowledge and follow through on the studies needed and the medications prescribed. He must convince the patient of his own sincerity, interest, ability, and whole-hearted involvement or all his medical knowledge is wasted. Failure to do so means the patient will feel rejected and will not cooperate. What examination measures these abilities which are the *sine qua non* of medical practice?

In judging performance we cannot use outcome alone as shown by Lindsay, *et al.*⁷ They did a quality-of-care assessment of the outpatient management of acute bacterial cystitis. The outcome was not much different whether the assigned criteria were followed carefully or not.

This is not surprising since many problems in medicine can be treated differently with the same outcome. That is not really the criterion. The patient wants quick relief of symptoms. It is not all art or science; these elements must be combined for the best mix. This is a complex problem. All of the continuing medical education, recertification examinations, and examinations for relicensure will not make the physician one iota better if he loses the human touch and forgets that it is a patient in front of him and not a computer problem.

Mueller pointed out that continuing examinations must be restructured, have different objectives and measure different facets of the patient care transaction than those given at the start of the physician's career.⁸ Continuing medical education is not enough. The goal also must be oriented toward continued medical production. It is the product of the trained physician that needs examination during the physician's productive years and not his knowledge. This is a most interesting thought and adds another facet to a problem which already may have too many facets.

Doctor B. Grey Dimond in *Accel* repropose an old suggestion of his that physicians take sabbatical leaves every five years.⁹ During this year a portion would be spent in "recreation" and a portion would be spent in a residency program to bring knowledge and techniques up to date. For many, this is the only way to learn—that is by "doing." From my point of view this is the ideal way to overcome obsolescence.

The Academy of Medicine of New Jersey has proposed "mini-residencies" to meet this need. Such a pilot program was inaugurated in the Department of Cardiology at the Newark Beth Israel Medical Center by Doctor Donald Rothfeld with outstanding success.

The financial and logistic problems of the sabbatical year demand much thought, but it is not an impossibility. The combination of recreation and rejuvenation of the medical mind truly would produce *mens sano in corpora sano* to the ultimate benefit of physician and patient.

SUMMARY

What have I tried to say about overcoming medical obsolescence and how to measure it? First of all, there is the probability that continuing medical education does improve patient care somewhat. Its greatest good is in the fact that it maintains the alertness and the interest of the physician and

^aGeorge D. Webster, M.D., "Assessment of Clinical Competence by certification," page 675, this issue.

^bWilliam C. Felch, M.D., "The Assessemtn of the Internist's Competence," page 669, this issue.

makes him cognizant of the fact that there are continuous changes.

Secondly, the sabbatical year with a residency could provide an excellent method for learning and improving performance. Thirdly, I do not believe that recertification (or relicensure) by an examination that measures knowledge alone is of any benefit. It is a true exercise in futility satisfying only those who give the examinations, but it is no panacea to improve the quality of medical care.

Fourthly, "evaluation of performance" is perhaps the best way to measure the physician's competence if we can develop a method truly to evaluate "performance" that is not too costly or time consuming.

Finally, we have been accused of not being very good policemen, i.e., not really doing the job when it comes to peer review. We have an opportunity to do this with PSRO. If we structure it properly and combine it with good medical audit, we may get a result which will be better than all of the other methods to evaluate obsolescence. With this knowledge we will be better able to structure our educational programs.

In conclusion, let us not yet become doctrinaire. I quote William Graham Sumner: "Doctrines are the most fright-

ful tyrants to which men are subject because doctrines get inside of a man's reason and betray himself against himself."

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CASE REPORT

Psoas Muscle Abscess as a Complication of Pott's Disease: Ultrasound Diagnosis

LAWRENCE GOULD, M.D. and
A. PAPARAO, M.D., Newark*

A patient with a psoas muscle abscess as a complication of Pott's disease is described. We emphasized the diagnosis by ultrasound utilizing a gray scale apparatus. Whereas x-rays are helpful in assessing the indirect mass effect of an abscess, gray scale ultrasonography provides direct information on the size, localization, and consistency of a mixed (solid plus fluid) lesion.

Abscesses have been described in the ultrasound literature in recent years and criteria have been established in order to facilitate their recognition in the body.¹⁻⁶ Although they have been reported in the liver, spleen, kidneys, and other organ systems of the abdomen, to our knowledge no description of a psoas muscle abscess as a complication of Pott's disease of the spine has appeared in the English literature.

Since abscesses are mass lesions containing variable mixtures of fluid and solid tissue, their size, consistency, and mass effects are amenable to study and evaluation by diagnostic ultrasound techniques.

The purpose of this communication is to report our recent experience at the Martland Hospital Medical Center with a patient who had Pott's disease and an associated psoas muscle abscess demonstrated by ultrasound.

CASE REPORT

A 36-year-old black male was hospitalized in February, 1977, with complaints of back pain, weakness, and a 70-pound weight loss going back to August, 1976. Pertinent physical findings included a tender gibbous deformity at L3, and an ill-defined fluctuant mass felt in the left lower abdomen extending down into the left iliac fossa. Positive laboratory findings included an elevated sedimentation rate (ESR) (55 mm per hour), a positive PPD skin test, and an elevated serum alkaline phosphatase. Barium enema x-rays

demonstrated displacement of the sigmoid colon superiorly and bone and disc destruction at the L3-L4 level. (Figure 1) A chest x-ray showed an ill-defined infiltrative process in the right upper lobe and atelectatic changes at the right base. The bone scan demonstrated increased uptake at T6-T8 and at L1-L4. This was interpreted as being consistent with an inflammatory reaction. A drip infusion intravenous pyelogram showed slight medial displacement of the left ureter at its mid portion. An inferior vena cavagram showed anterior displacement from the spine at the site of the osseous lesion. (Figure 2) Although sputum cultures and stain were consistently negative for the presence of acid-fast bacillus, a biopsy obtained from the L4 area showed caseating granuloma and a presumptive diagnosis of Pott's disease was made. An ultrasound examination of the abdomen on March 10, 1977, demonstrated a large cystic lesion measuring approximately eleven cm. in length and seven cm. in height, best demonstrated in a longitudinal plane five cm. to the left of the midline. (Figure 3) On transverse echotomograms its peripheral position was documented best at eight cm. above the symphysis pubis. (Figure 4)

Although the lesion was primarily cystic in composition,

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Figure 1—Film from barium enema study shows vertebral body and disc changes characteristic of tuberculosis. Note superior displacement of sigmoid colon from mass.



Figure 2—Inferior vena cavagram shows anterior displacement of the inferior vena cava from the spine secondary to the lesion in the spine.

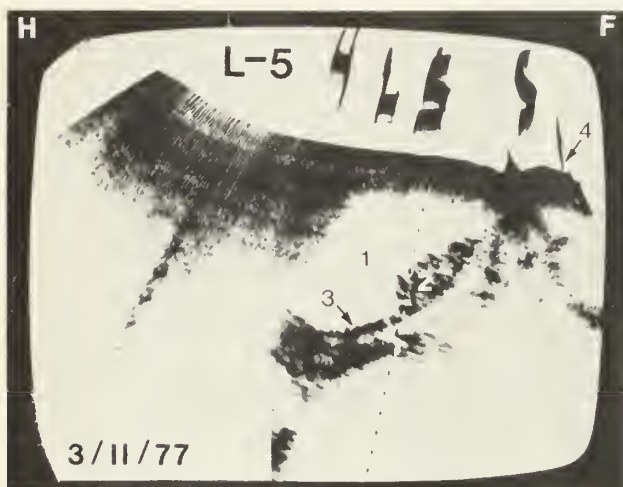


Figure 3—A longitudinal cut, 5 cm. to the left of the mid-line shows the cystic mass with echogenic debris located along the posterior wall.

H=Direction of Head; F=Direction of Feet; 1=cystic mass; 2=tissue debris; 3=posterior wall abscess with wall enhancement. 4=Position of symphysis pubis for orientation.



Figure 4—A transverse cut, 8 cm. above the symphysis illustrates the lateral position of the mass in relationship to the mid-line.

R=right side of patient; L=left side of patient; 1=cystic mass; 2=tissue debris; 3=mid-line of patient's anterior abdominal wall.

multiple echogenic areas were demonstrated adhering to the posterior wall which did not change in position. On the longitudinal "cut" the fluid could be demonstrated adjacent to the posterior wall. Posterior wall enhancement can be seen. Acoustic shadowing was demonstrated posterior to the echogenic shadows previously mentioned. The findings described are consistent with a large cystic lesion containing fluid and tissue debris.

In April, 1977, an anterior-lateral fusion of the spine was performed. Biopsy at the time of surgery revealed caseating granuloma of the vertebral bone with fibrosis. Tissue from

the cyst wall yielded caseating granuloma and evidence of chronic inflammation. A repeat ultrasound study in June, 1977 again demonstrated the abscess which was only slightly smaller in size.

DISCUSSION

According to various evaluations, skeletal tuberculosis occurs in about three to five percent of cases of pulmonary tuberculosis.^{7,8} Osseous tuberculosis is assumed to occur on the bases of hematogenous spread from a pre-existing extra-skeletal focus. It is estimated that about half of the

cases occur in the vertebral column and 75 percent of these are located between T6 and L3. The most characteristic radiological feature is the narrowing of the disc spaces in association with deformity of the vertebral bodies. The usual bony deformity is erosion and gouging out of the end plate surface. A gibbous contracture often is demonstrated.

Psoas abscess, which frequently occurs in vertebral tuberculosis, is known as a cold or "burrowing" abscess and has certain distinctive features. These lesions can spread for a large distance and have the ability to perforate through the skin or to penetrate into body organs. They tend to spread in a lateral vector along the path of the psoas muscle and only rarely do they ascend superiorly, presumably because of the anatomic barrier of the diaphragm. Pus is contained within the abscess; it has been noted that, as the abscess enlarges, the inner wall tends to disintegrate and forms irregular masses of decrepit caseous material.

X-RAY FINDINGS

X-rays have been an aid in the evaluation of psoas abscesses and often are diagnostic. A calcified psoas muscle in a known case of tuberculosis is pathognomonic of a psoas abscess. X-rays are also helpful because of the mass effect of the abscess against such contingent structures as the colon, ureter, and great vessels. The appearance may be confusing, as in the case presented here. For example, the ureter in a psoas abscess usually is displaced laterally, but in this instance it was displaced medially. The abscess usually commences at the insertion of the psoas muscle medially; in our patient it manifested itself peripherally. Diagnostic x-rays cannot provide information on exact size, margin irregularity and intrinsic consistency, unless calcification or gas bubbles can be described within.

ULTRASONOGRAPHY

Gray scale ultrasonography can reveal precise information on the size of a mass, the presence or absence of calcification

(which may not be appreciated on a plain film), and the degree of fluid from a liquefaction process. Cystic lesions can be diagnosed if they demonstrate the classic triad of:

- 1. Clear-through transmission at high gain.
- 2. Posterior wall sharpness.
- 3. Posterior wall enhancement shadows.

Mixed lesions also can be demonstrated if the cystic areas are intermingled with echogenic tissue debris. Gray scale ultrasonography can be used for localization and for aspiration techniques. It is an excellent modality to follow the size of an abscess as the healing process progresses. Thus, serial measurements may be obtained regularly to measure the response to chemotherapy or to evaluate the end result of surgical drainage.

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Psoriasis and Recent PUVA Therapy

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Psoriasis affects two to three percent of the world's population, but its etiology remains elusive and treatment is palliative. PUVA photochemotherapy, a new but unapproved therapeutic modality, is discussed.

Psoriasis is a worldwide skin affliction of ancient derivation, affecting some two to three percent of the population. The most usual picture is that of a patient with annular, scaly, reddish, dry patches on the elbows and the knees. However, psoriasis may be much more widespread or it may be restricted to the scalp or to the nails. A so-called, pustular psoriasis, oftentimes is restricted to the palms and/or the soles. The symptoms may be negligible or there may be pruritus and an associated arthropathy. Primarily, the condition is not aesthetic.

The **histologic features** are those of elongated rete pegs, inflamed dermal papillae with a banal infiltrate, and parakeratotic scaling.

The **cause** of psoriasis is enigmatic despite much diligent research and the availability of tissue for study. There is a 25 percent history of inheritance among psoriatics and it is considered that psoriasis behaves as an autosomal irregular dominant. There is some evidence that the pathogenesis is related to an abnormality of the keratinization cycle; the turnover rate of the epidermis is about one-eighth or less of the normal.

TREATMENT

The **treatment** of psoriasis has taxed the wisdom of man and the medical profession since biblical times. To succeed, more effort is required than many patients who do not feel ill are willing to undertake. At this point, a "cure" is unobtainable, but the process may be brought under satisfactory control or remission for a varying length of time. As in many

medical situations, the prognosis is improved when the condition is vigorously attacked at its earliest appearance.

Mild cases generally may be controlled with topical means, including coal-tar derivatives and corticosteroid preparations, either separately or in combinations. Widespread eruptions have shown good response to the Goeckerman regimen, a method which has been in use for over 50 years. Patients are hospitalized or treated in "day-care centers." After application of a crude coal tar preparation the skin is exposed to ultra-violet light, generally on a daily basis. Ionizing radiation has fallen out of use, due to adverse publicity and long-range sequelae. Chemotherapy with methotrexate, a folic acid analogue is reserved for a group of patients that satisfy strict criteria for its use. It has proved beneficial in suppressing the psoriasis.

PUVA PHOTOCHEMOTHERAPY

One of the most impressive therapeutic advances in the history of dermatology has been the development of PUVA photochemotherapy for psoriasis.^{1,2} Averaging 40-mg doses of methoxsalen (8-methoxypsoralen [8-MOP]) and two to three weekly exposures to long (320-390 nm) ultra-violet light (UV-A), relatively complete clearing may be achieved in approximately 70 to 90 percent of the patients. The dosage of 8-MOP is estimated according to body weight; the average adult (66-80 kg) takes the 40 mg with food, two hours before

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the light treatment. This UV-A dosage is calculated in joules and is administered according to anticipated tolerance, based on the patient's degree of pigmentation and his ability to tan and his susceptibility to sunburn. Currently, an extensive cooperative study is under way at some 20 medical centers, using sophisticated equipment, the most important component being high-intensity UV-A lamps distributed from top to bottom, on all four sides, with internal reflecting shields in each lamp bulb. The construction guarantees that all portions of the skin except the soles and the scalp will receive relatively equal amounts of radiation with the patient standing in the center of the chamber. These units are expensive and will not be available until the Food and Drug Administration approval is obtained (now thought to be so at the end of 1978).

Alternative modalities of PUVA photochemotherapy also have been evaluated in the treatment of psoriasis, using a conventional Zimmerman cabinet, containing 30 standard four-foot blacklight fluorescent bulbs (GE F40 BL) and an average dose of 8-MOP at 60 to 70 mg. Treatments were given three times a week and the response was quite acceptable after an average of 20 treatments.³

As with many cooperative medical studies, some type of protocol is followed. Pretreatment work-up includes a general laboratory survey, skin biopsy, photographs, and an eye examination by an ophthalmologist. In addition, the patients are instructed as to the possible risks, side effects, and the experimental nature of the treatment. During each treatment, the patient has the eyes protected by appropriate sun-goggles and the face is covered with a sun-screen, as it usually is not involved. An attendant supervises and observes each individual treatment and the dose-time is charted; depending upon the response, an increase, decrease or perhaps a skip in the therapeutic schedule is administered that day. PUVA has its advantages and disadvantages, just as

any other modality. It has shown satisfactory control in the majority of the patients treated to date, but there also have been exacerbations, following cessation of therapy, requiring another course of treatment. It is time-consuming for both the patient and the personnel involved in this modality. It is relatively expensive for the patient. PUVA therapy is not encouraged for the more common psoriatic patients, but the future does look brighter for the people with severe psoriasis who had been unable to acquire any control with previous systemic or topical means.

SUMMARY

In spite of the enigma of psoriasis, man has attempted to control this problem in a variety of ways. Fortunately, many patients with the more localized forms of this condition can be helped through the attention of the concerned physician and the cooperation of the affected patient. There are newer topical medications and there may be additional topical and/or systemic measures applicable in the near future. Currently, the most discussed and the most concentrated evaluation, centers about PUVA photochemotherapy. The future does look brighter with this modality expected to become available in about a year. Modifications will permit an easier access for the majority of patients who may need this form of treatment.

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Important Note: When it is judged necessary that treatment be initiated before definitive culture and sensitivity results are known, the choice of cloxacillin sodium should take into consideration the fact that it has been shown to be effective only in the treatment of infections caused by pneumococci, Group A beta-hemolytic streptococci, and penicillin G-resistant and penicillin G-sensitive staphylococci. If the bacteriology report later indicates the infection is due to an organism other than a penicillin G-resistant staphylococcus sensitive to cloxacillin sodium, the physician is advised to continue therapy with a drug other than cloxacillin sodium or any other penicillinase-resistant semi-synthetic penicillin.

Recent studies have reported that the percentage of staphylococcal isolates resistant to penicillin G outside the hospital is increasing, approximating the high percentage of resistant staphylococcal isolates found in the hospital. For this reason, it is recommended that a penicillinase-resistant penicillin be used as initial therapy for any suspected staphylococcal infection until culture and sensitivity results are known.

Cloxacillin sodium is a compound that acts through a mechanism similar to that of methicillin against penicillin G-resistant staphylococci. Strains of staphylococci resistant to methicillin have existed in nature and it is known that the number of these strains reported has been increasing. Such strains of staphylococci have been capable of producing serious disease, in some instances resulting in fatality. Because of this, there is concern that widespread use of the penicillinase-resistant penicillins may result in the appearance of an increasing number of staphylococcal strains which are resistant to these penicillins.

Methicillin-resistant strains are almost always resistant to all other penicillinase-resistant penicillins (cross-resistance with cephalosporin derivatives also occurs frequently). Resistance to any penicillinase-resistant penicillin should be interpreted as evidence of clinical resistance to all, in spite of the fact that minor variations in *in vitro* sensitivity may be encountered when more than one penicillinase-resistant penicillin is tested against the same strain of staphylococcus.

Contraindications: A history of a previous hypersensitivity reaction to any of the penicillins is a contraindication.

Warning: Serious and occasionally fatal hypersensitivity (anaphylactoid) reactions have been reported in patients on penicillin therapy. Although anaphylaxis is more frequent following parenteral therapy it has occurred in patients on oral penicillins. These reactions are more apt to occur in individuals with a history of sensitivity to multiple allergens.

There have been well documented reports of individuals with a history of penicillin hypersensitivity reactions who have experienced severe hypersensitivity reactions when treated with a cephalosporin. Before therapy with a penicillin, careful inquiry should be made concerning previous hypersensitivity reactions to penicillins, cephalosporins, and other allergens. If an allergic reaction occurs, the drug should be discontinued and the patient treated with the usual agents, e.g., pressor amines, antihistamines, and corticosteroids.

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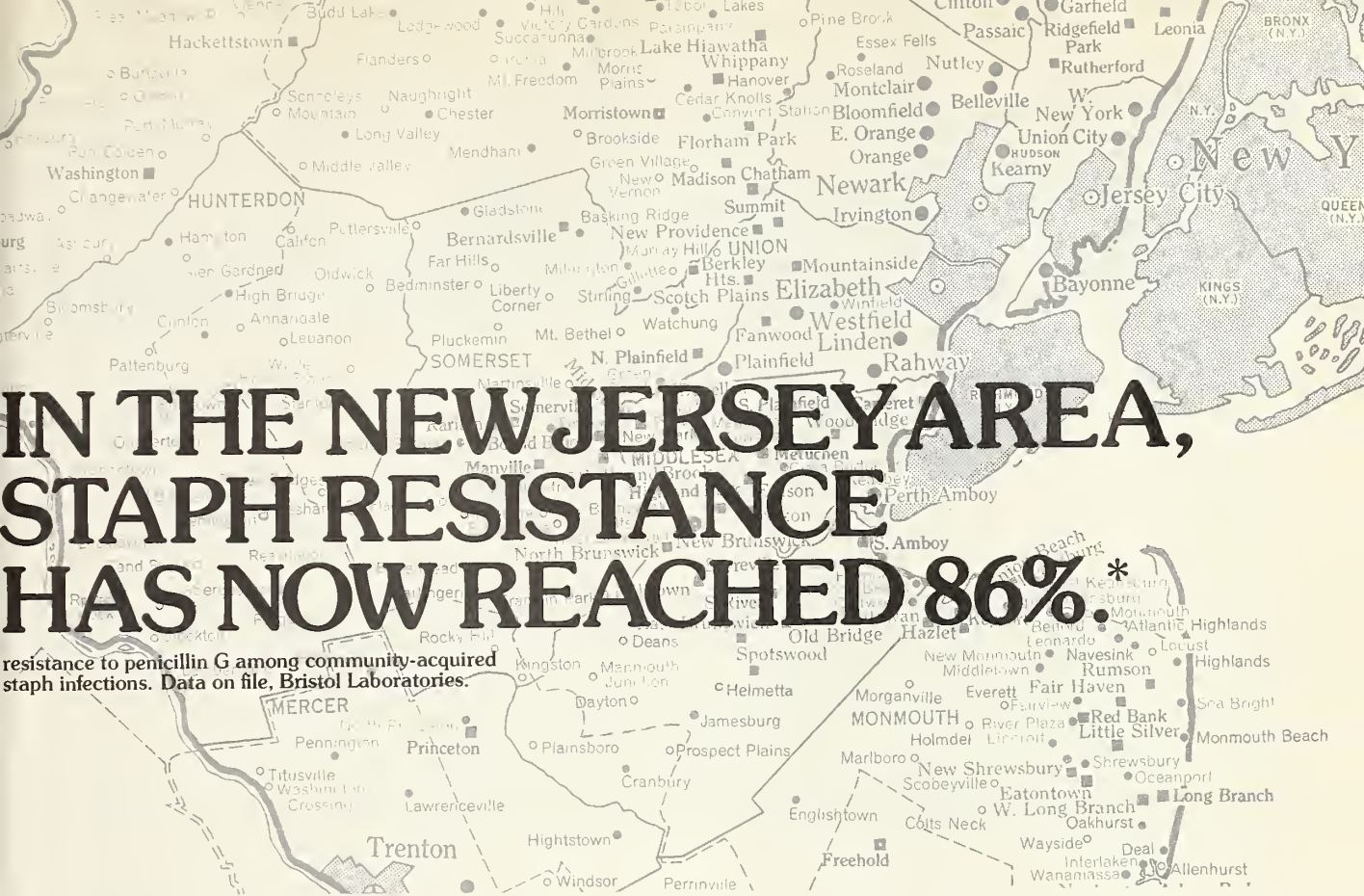
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Agenda for Survival of the Traditional System of Medical Practice

SANFORD M. LEWIS, M.D., East Orange*

Health care costs are increasing to a point which seriously threatens the integrity of the free enterprise system. Numerous interventions on federal and state levels, already implemented or in the planning stage, may threaten quality of care. Progress in stabilizing the existing mode can be made only if physicians profoundly alter attitudinal responses to fiscal realities.

The practicing physician concerns himself primarily with his patients' medical welfare. Thereafter, in descending order of emphasis, he may rate preservation of the traditional practice mode, his personal financial status, the financial burdens of his patient and finally, if at all, the cost of the system. Trained to focus on the individual, he develops a sympathetic myopia which enhances therapeutic skills while simultaneously blurring his perception of financial substrates for the health care process in toto. Should he experience the subacute discomforts initiated by critical headlines or rumored regulations, he applies an ancient anodyne: The physician must act for his patient, it becomes the responsibility of others to insure the fiscal means. The hand that holds the scalpel, he reasons, must not be deflected in trimming the budget.

These attitudes, sanctified by time and reinforced by a system which consistently produces an unparalleled level of quality medical performance, prevailed when the writer completed his training during World War II. Despite subsequent substantial societal changes they remain essentially unaltered today. Certainly a powerful new element preventing change is the perceived need for "defensive medicine" occasioned by proliferating malpractice actions and awards. And yet it is change—profound attitudinal and procedural change—which already is overdue. Having reached a point very close to maximal financial load, the faltering system requires—*now*—serious and sustained attention from the physician as

well as the administrator, the legislator, the planner, and, the economist. If we can accept the need, we have begun the process of understanding the "why" and "how."

We witness, currently, a determined shift toward consumer orientation of regulatory boards and agencies. Since a "producer"¹ under various definitions may include healer, health administrator, health insurer, health educator and para derivatives of these categories, it becomes apparent that key decisions may soon belong to the consumer whose qualifications appear to be innocence of sophistication in health problems beyond his own experience. If this trend represents a political gesture toward "liberalism" rather than well-considered planning, it may exacerbate already critical problems. Should other physicians hold, together with the author, that it is our expertise together with that of administrative specialists which should be brought to bear upon the decision-making process, we simultaneously cannot continue to demand, in the daily pursuit of medical practice, that we remain insulated from such involvement. Either the physician joins the health team as something more than a skilled technician or he abrogates his right to participate in planning for its evolution. He must be "Captain of the Ship," not only when the salutes are fired, but when the bills are paid!

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Health expenditures rose from 5.2 percent of gross national product in 1960 to 8.6 percent in 1976 and the slope steepens. A large percentage of this cost may be traced to the in-hospital patient day which currently climbs uncomfortably from the \$200 toward a \$300 level. Since, however, in excess of 90 percent of hospital care is met by third-party payors,² the patient and often the physician are only dimly aware of the origins of costs, the rate-setting process, and the impact of medical decision upon medical bill. One orders a single test or test groups at modest expense. But many physicians order many procedures and the growth of capital expenditures parallels that of multiplying operating costs. The reimbursement process, acting almost independently of physician input, struggles to keep pace and, quite consistently, fails to do so. If to these difficulties are added the inexorable impact of inflationary trends in labor, fuel, insurance, food, and supplies, it becomes understandable that we approach overload. The system falters.

"Most Americans feel high hospitalization costs and physicians fees cannot be justified by the quality of U.S. health care." This Harris poll result attracted recent national press attention.³ The Carter administration moves to impose a standard 9 percent ceiling on annual increases in hospital revenues, perhaps overlooking the fact that the same lid scarcely can seal every jar. In almost every state, legislators, commissions, task forces, and boards wrestle to control the accelerating deficit. In Massachusetts, for example, alternative health plans are receiving considerable experimental attention⁴ and, from the same sector, David Kinzey, President of the Massachusetts Hospital Association, admits that "in terms of where we are now, it is an understatement to say that nobody knows how to put such a control system together."⁵ Admitting the awesome dimensions of the problem, we soon may reach the point of willingness, as professionals and as a profession, to join the expanding corps of those who already have assigned major priority to developing effective responses.

That work has begun, indeed it extends well beyond the early stages of implementation. Federal legislation and the New Jersey Health Care Facilities Planning Act of 1971 have mandated a proliferation of bodies (Health Service Agencies, State Health Planning Councils, the Health Care Administration Board, and others) which accept the official burden for planning and decision. In the private sector there is equal vigor. The New Jersey Hospital Association, for instance, has sponsored the "Voluntary Cost Containment Committee of New Jersey" which presently is addressing problems by organizing a task-force for each potentially productive area.⁶ Exhaustive examination is being directed toward preadmission testing, effective use of beds and specialized patient services, shared services, regulation compliance, utilization and benefits, hospital personnel, and education programs. Physicians, along with other professionals, have volunteered for each category of inquiry. These interventions, along with PSRO, HMO, de-institutionalization, the day-hospital, and others may stem the tide—for awhile.

Ultimately, however, the individual physician in practice must, in my view, begin to think just as automatically about the cost of each procedure as its medical indication. His analysis of the success of clinical efforts must include, at least in part, an estimate of how carefully he has restrained the expenditure of monies provided by others. It is admittedly psychologically awkward to expect anyone but the payor to "feel" the true burden of costs. What is difficult, however,

is not impossible if we accept constructive re-programming. The physician's "father" role directs empathic energy toward the alleviation of biologic suffering. It perhaps can be extended and, in full dimension, take mature responsibility also for the preservation of fiscal integrity. There may be value in examining methods by which such growth may be facilitated.

An exploration of new areas validates the "think-tank" approach in which preliminary ideas may be voiced without reticence in the hope that some may survive as innovative techniques worthy of further examination. Can we perhaps here begin such an effort, progressively add to it and eventually, through our organized bodies, refine and implement that which seems useful? In recent years we have become accustomed to the term "psychiatrically-oriented" which liberally translated means "I've heard about it but prefer to let someone else tend to the revolting details." "Orientation" in the economies of medicine will no longer suffice. We must, it seems clear, wield the scalpel as effectively on the budget as we do for the patient.

Another caveat is "Education"—a glorious word with multiple connotations. Its appearance on a planning list, however, adds little to progress. Many among us rest comfortably assured that we are training, at least our youth, in the necessity for fiscal awareness. Perhaps there has been some progress. Recently, however, I asked a third-year student how he would follow up his patient with essential hypertension for whom he had prescribed a mild diuretic. His answer: "I'll follow his potassium," helps to shatter illusions. Apparently we still somehow teach that one follows a "potassium" rather than a patient, and there remains blithe unawareness that a brief history and simple examination is much more to the point and considerably less costly than directives to a laboratory technician.

Returning then to the "think-tank" and its protective disclaimer, I'd like to venture some distinctly embryonic ideas which may catalyze more productive concepts by others:

1. **The Team Approach**—Upon hospital admission, the patient is assigned both to his physician and an expediter. Medical doctor and "environment-doctor" consult together in the patient's interests. The latter, having developed intimate knowledge of the hospital, its personnel and its idiosyncracies, thus serves to facilitate, hasten, and otherwise improve the entire process in personal and fiscal terms. If a physician can treat numerous persons so may the expediter, thereby effecting considerable savings beyond his own compensation. The new professional programs the (hospital) environment while the doctor treats the patient.

2. **Financial Rounds**—We traditionally meet to analyze case histories in terms of diagnostic maneuvers, efficacy of therapy, and reasons for failure. Periodically it may be possible to examine prototype cases from a cost viewpoint, with the same line-by-line, analytic intensity usually directed toward clinical factors. Such repetitive exercises, gradually effecting behavioral modification, surely must enhance awareness of and receptivity toward acceptance of a philosophy of restraint.

3. **The Standing Committee**—The Hospital Association approach has been described. It may serve as a model for adaptation within each hospital unit. Institutional performance, as measured by state rate-setting processes can be examined and compared. Peer review among physicians may be supplemented by peer review among hospital staffs, with the measure being degrees of success in the several para-

meters of cost containment.

4. **The "Institute of Medical Economics"**—When complex problems require sustained consideration among a diverse group of interested entities, there often arises a centripetal movement toward institutionalization of response. Thus the "Institute" which may serve a coordinating umbrella function, bringing together hospitals, physician groups, planners, educators, and legislators within an organized setting. If the wheel can be invented but once, and thereafter progressively refined, progress results. Details are premature at this writing. The concept aims toward effectiveness through centralization, coordination, and continuity.

For decades physicians have, as individuals, enjoyed the privilege of assigning the problems of fiscal responsibility to others. That perquisite, among others, is fading fast. Limits are being reached. The need is now clearly apparent for "all

the help we can get" if the traditional system of medical care is to survive reasonably intact. Since that system is most certainly productive of the highest qualitative levels of medical care for those it reaches, it is eminently worth preserving and expanding. If the medical practitioner now will commit himself fully to lending his strength in the crisis of cost containment, there is reason for guarded optimism.

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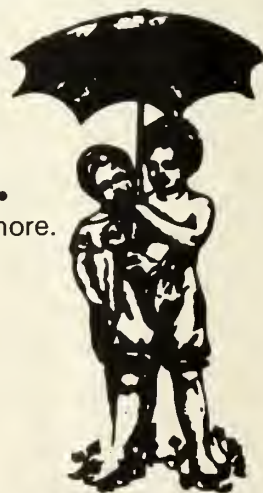
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Selected Abstracts with Comments*

A Double-Blind Controlled Crossover Trial of an Antigen-Avoidance Diet in Atopic Eczema. Atherton DJ, *et al*—*Lancet* 1:401 (1978).

Twenty children with typical atopic eczema aged 2 to 8 years were placed on a diet which excluded all eggs, chicken, beef, and cow's milk. All served as their own controls. Fourteen of the twenty did better during the period of restriction. Skin tests did not predict which would respond to restriction since all had positive tests.

Comment: I cannot do justice to this in summary. This is a small study but was controlled carefully. The authors used an "artificial mixture" which either had a soy base or had an egg and milk base as the source of the questionable substance. The diets were otherwise identical. The likelihood is overwhelming that there was benefit from the dietary restriction. Eczema is complex. Many infants do not respond to any or all manipulations of diet. However, Soothill has shown that breast feeding is effective in prevention. This same group now brings this hard evidence re therapy in young children. (R. Rapkin, M.D.)

The Role of Antibiotics, Immunizations, and Adenoviruses in Pertussis. Baraff LJ, *et al*—*Pediatr* 61:224 (1978).

Clinical pertussis was identified in a large group of infants. Most (75 percent) had the organism isolated. Erythromycin cleared the organism rapidly but had no effect on symptoms. Adenovirus was isolated from only 10 percent of patients. These also had B. pertussis isolated and antiadenoviral antibodies did not rise in paired sera. Subsequent B. pertussis antibodies were not found reliably even in patients who had the organism isolated.

Comment: This article confirms current knowledge. B. pertussis is the etiology of the vast majority of whooping cough cases. Good culture technique, freshly prepared media, and early cultures very often grow the organism. Antibodies, viral isolation, viral serology, and fluorescent staining are rarely helpful in diagnosis. Erythromycin is effective in rendering the patient non-contagious but has no value clinically. (R. Rapkin, M.D.)

History of Recurrent Sore Throat as an Indication for Tonsillectomy. Paradise JL, *et al*—*N Engl J Med* 298:409 (1978).

Sixty-five children with strong histories of frequent and severe sore throat were followed for one year. Eighty percent

of such children had a substantial reduction in frequency and most episodes were mild. Histories of sore throats do not forecast subsequent experience and are not a valid indication for tonsillectomy.

Comment: This simple study is indicative of what must be done before any more tonsillectomies are performed. We must have carefully controlled studies which demonstrate what normal is before we can label something abnormal. The only clear-cut indication for tonsillectomy known in 1978 is the hypoventilation cor-pulmonale syndrome of tonsillar-adenoidal obstruction. All of the rest (including peritonsillar abscess, large tonsils, frequent "strep throats," failure to eat well, and so on) must be considered experimental until studied and proved to be helped by this ancient, historic but superfluous procedure. (R. Rapkin, M.D.)

Normal Blood Pressure and the Evaluation of Sustained Blood Pressure Elevation in Childhood: The Muscatine Study. Rames LK, *et al*—*Pediatr* 61:245 (1978).

School children (5 to 18 years old) in predominantly white (>90 percent) Muscatine, Iowa, had blood pressures (BP) measured in two surveys over a four year period. Seventy percent of eligible children participated. A rise in systolic and diastolic pressures, especially in the preadolescent years was demonstrated; 13.4 percent of all children screened (total 6,622) had systolic BP above 140 mm Hg or 95th percentile for age, or diastolic BP above 90 mm Hg or 95th percentile for age. When repeated measurements were made only 41 (or 0.6% of the total population) had sustained hypertension. Fifty-six percent of those hypertensives were "obese" and almost half had normalization of BP with weight reduction. None had other causes identified for hypertension. Of the lean subjects, 11/17 had essential hypertension and five had identifiable causes of secondary hypertension.

Comment: This study again points out that essential hypertension is a real entity in childhood (and especially in adolescence); BP in children is often labile; obesity is a common reversible cause of hypertension (independent of artifacts due to cuff size). The authors stress the difficulties

*Abstracted from "Pediatric Department Newsletter," RMS. Vol. 2, No. 8 (April 1978). Selections are made and original comments prepared by Richard H. Rapkin, M.D., Professor of Pediatrics, RMS, CMDNJ, and his associates.

and expense of this type of screening survey. Pediatricians have a captive population, however, and little extra time and expense is generated by incorporating routine BP measurements into well-child care. Reliable normal values for age (at least for the Caucasian population) are now available based on "casual" (usual office conditions) rather than basal measurements (see *Pediatrics* Supplement, May, 1977) and the follow-up of patients identified as "abnormal" (beyond the 90th or 95th percentile) can be incorporated into routine care. The most disturbing aspect of the study concerns the lability of pediatric BP. There is evidence in adults that "labile" hypertension is a significant precursor of sustained hypertension in later life. If this is true for children, then increased longitudinal surveillance and later appropriate intervention would seem to be important for prevention of the morbidity associated with high BP in adults. Serial observations on the Muscatine children would be most useful. (S. Kleeman, M.D.)

Dose-Response Relationship of Diazoxide in Children with Hypertension. Boerth Robert C, *et al*—*Circulation* 56:1062 (1977).

One infant and 15 children with severe hypertension (mean admission BP=178/130) of diverse etiologies were treated with diazoxide utilizing a variety of regimens. All injections were rapid intravenous pushes with doses ranging from 2.75 mg/kg. Analysis of responses demonstrated considerable variation between individuals (3 mg/kg/dose produced a fall in diastolic BP from 4-40 mm Hg), but there was a consistent dose-response relationship for any individual patient. Furthermore, if given at 10 to 15 minute intervals, a cumulative effect of the drug on BP was demonstrated.

Comment: This study provides increased flexibility in the use of diazoxide, the *potent* parenteral anti-hypertensive agent with which pediatric experience is greatest. The authors demonstrated a cumulative effect of this drug which can be used to titrate dose vs patient's response; the resulting effective dose (e.g. 2 mg/kg x 2 → 30 mm drop in diastolic BP) providing a basis for the appropriate dose of diazoxide for subsequent therapy (4 mg/kg in the "patient" just described). (S. Kleeman, M.D.)

Renal Vein Thrombosis: Diagnosis by B-scan Ultrasonography. Fowler JE, *et al*—*J Urol* 118:849 (1977).

A previously healthy, post-partum female developed right flank pain, and gross hematuria. IVP showed non-visualization on the right side; cystoscopy demonstrated bloody efflux from the right ureteral orifice. A B-scale ultrasonogram revealed irregular echoes in the inferior vena cava (IVC) and enlarged, non-obstructed right kidney. This thrombus extending to the right renal vein orifice was confirmed by venography and the patient successfully treated with anticoagulants.

Comment: Ultrasonography appears to be an excellent, non-invasive screen for renal venous thrombosis (RVT) utilizing the findings of disparity of size and lack of obstruction of the enlarged kidney along with a thrombus in the IVC (seen in almost 50 percent of patients with RVT). In patients prone to this disorder (hypercoagulable states, such as nephrotic syndrome) identification of this complication may lead to early appropriate therapy to prevent life-threatening sequelae such as pulmonary embolization.

(S. Kleeman, M.D.)

Intellectual Development and School Achievement of Youths 12 to 17 years: Demographic and Socioeconomic Factors. Vital and Health Statistics, Series 11, No. 158, U.S. Department of HEW.

Intellectual development and school achievement of youths 12 to 17 years of age, as measured by the vocabulary and block-design subtest of the Wechsler Intelligence Scales for Children and the reading and arithmetic subtest of the Wide Range Achievement Test, are discussed. These tests were administered from 1956-1970 as part of a national health survey of HEW. The educational level of the parent who was considered to be the head of the household was the variable most highly correlated with the scores. The correlation was a positive one. There was also a strong relationship between family income and test scores which was positive. Youths residing in those areas experiencing above average gains in population consistently obtained higher scores than those in communities with declining population. There was a gross difference in average scores in youths from the major racial groups, but for both whites and non-whites, the relationship with family income and education exhibited the same pattern of quantitative relationships. However, the racial differences appeared in all groups regardless of family income or education.

Comment: These are basic data well known to most physicians. However, only by documenting and then restudying changes with time, as well as searching for other variables which may be influential, will we be able to effect meaningful changes. (A. Katcher, M.D.)

Improvement in Infant and Perinatal Mortality in the United States, 1965-1973. Eisener Z, *et al*—U.S. Department of HEW, Publication No. HSA 78-5743.

Infant and perinatal mortality in the United States during the period 1965-1973 has declined progressively. The decline of post-neonatal mortality rates was greater than the decline of fetal and neonatal mortality rates. Other-than-white infant and fetal mortality rates improved more than the white rate except in the first day of life. Post-neonatal mortality rates improved more in rural than urban areas while neonatal and perinatal mortality rates improved more in urban areas than in rural. Improvement was greatest in those states that had the highest mortality rates and the lowest per capita incomes in 1965. The relative position of the United States in comparison with other countries has not changed. The number of fetal deaths at 20 weeks gestation and above comprise 41 percent of all reported infant and perinatal deaths and the neonatal loss comprises 43 percent of those deaths. Fetal and neonatal mortality rates are 2 to 3 percent higher than the post-neonatal rates and the rates of decline are lower.

Those states showing a combination of large size, high infant mortality rates, and slow rates of decline of mortality rate include Illinois, Indiana, Michigan, Texas, North Carolina, and Pennsylvania, but not New Jersey. Of 56 large cities, ten displayed these characters, but none was in New Jersey.

Comment: This is a monumental and comprehensive study which is well worth review by all physicians interested in this area. It was not possible for the authors to describe the reason(s) why the mortality rates have been falling. Efforts to correlate this with the development of perinatal intensive care were not successful. There was some suggestive evidence that the decline might be related to a decline in the number of pregnancies occurring in high-risk mothers:

a reduction in births to the very young and very old mothers and the reduction of births at high parities. There is obviously a need for continued research in this area and still no reason for complacency. A striking finding was the tremendous variation from one community to the next and one state to the next, a variation which cannot be accounted for on the basis of obvious demographic or other factors except that rates continue to remain high in the south and higher among the non-white. (A. Katcher, M.D.)

Child Deaths in New Jersey—Social Characteristics. From Bureau of Research, Planning, and Program Development, Division of Youth and Family Services, Trenton, N.J. (1977). This is a study of deaths occurring in children in New Jersey in 1974 and a study which compares those deaths with deaths occurring in children who were supervised by the Division of Youth and Family Services. The pattern of child death in New Jersey does not differ significantly from the national statistics. Homicides account for about 5 percent of all deaths in the 1 to 14 year old group, and the 15 to 24 year old group has a much higher homicide rate. Males and non-white males are over-represented as homicide victims.

In children who were supervised by the Division of Youth and Family Services, certain patterns are apparent. Fifteen fewer deaths were recorded in the DYFS population as caused by natural disease. The proportion of homicide was twice as high and accidents and traumatic deaths were significantly higher. There was no change in the sex frequencies. The DYFS population is drawn disproportionately from households which are poor, single parents, and non-white, all well known to be related to mortality risk. Fifty percent of the DYFS children who died in 1974 died of accidents, homicide, undetermined trauma, sudden or unknown death, or suicide. This compares with only 18.5 percent of deaths caused by similar causes in the same age population in New Jersey in general.

Comment: This study is a beginning analysis by a large state agency. It is of significance to doctors who take care of children supervised by DYFS and it is hoped that it will result in further scrutiny by this agency, perhaps in association with other agencies (e.g., The Protective Services Research Institute) to search for risk factors which could be used as the basis for a preventative program.

(A. Katcher, M.D.)

Amoxycillin and Co-trimoxazole (TMP-SMX) in Presumed Viral Respiratory Infections of Children: Placebo-Controlled Trial. Taylor B, *et al—Brit Med J* 2:552 (1977).

Children with URIs who had strep excluded by culture were treated with either of the above agents or a placebo. There was no difference among the regimes in overall value.

Comment: This study would seem superfluous but for the continued promiscuous use of the antibiotics for viral disease in the hope of "preventing complications". It doesn't work. I wish that it did. (R. Rapkin, M.D.)

Evaluation of Penicillin Hypersensitivity. Green GR, *et al—J All Clin Imm* 60:339 (1977).

A (massive) multicenter study of 3000 patients has demonstrated that skin tests to Penicillin G and penicilloyl-polylysine (PPL—now commercially available) predict and confirm penicillin allergy. Nineteen percent of patients with a history of penicillin reaction were positive to either, com-

pared to 7 percent of controls. A history of anaphylaxis led to 46 percent positive. Those with a history of urticaria were positive 17 percent and those with maculopapular eruptions did not differ from controls (7 percent positive). Challenge with penicillin led to a reaction in 6 percent with a positive history (compared to 2 percent with a negative) and 67 percent with a combined positive history and positive skin test (to either). Only 3 percent of those with negative skin tests had a positive reaction (and most of these were mild).

Comment: PPL is now available. Penicillin G is available. Performing scratch tests, then intradermal tests with these materials in patients with strong histories will identify those at risk. In patients with poor histories (non-specific rash) or negative skin tests the risk is negligible.

This study should be read by all clinicians. Reprint requests should be sent to Dr. Green at 1245 Highland Avenue, Abington, Pa., 19001. (R. Rapkin, M.D.)

Needle Aspiration Biopsy. Kline TS, *et al—JAMA* 239:36 (1978).

Fine-needle aspiration biopsy was used over an eight-year period in more than 3000 patients. A standard 18 or 22 needle attached to a syringe was inserted into the area in question, rotated vigorously while suction was applied, and then removed. The aspirate was ejected onto slides for appropriate staining. The procedure was accurate 90 percent.

Comment: Dr. Sidney Gellis has, for years, admonished us to use needles to puncture questionable disease areas. Willie Sutton is another proponent of procedures that directly attack the area. This article describes a simple procedure for lymph node biopsy, and evaluation of lung, subcutaneous nodules, and so on. We must be aggressive to make effective diagnoses. No need to spend \$500 or \$1000 on a major workup which skirts the problem, rather than direct biopsy using easily available materials. (R. Rapkin, M.D.)

Febrile Seizures and Later Intellectual Performance. Ellenberg JH, *et al—Arch Neurol* 35:17 (1978).

Four hundred and thirty-one sibling pairs (one of whom had a classical febrile seizure) had IQ tests at age seven years. There were no differences. Even prolonged (30 minutes) or recurrent seizures had no association with IQ deficit. Children with previously known neurologic disease were excluded. This study shows that "... documentation of the status of children before the first seizure ... is ... of major significance ... the ... characteristics of the child before any seizure were related to intellectual status and not the occurrence, clinical type, nor number of febrile seizures. ...".

Comment: This immense study raises the same old questions but places them in a new perspective. The authors raise the issues of importance:

1. Since the possibility of intellectual impairment is a major reason for seizure prophylaxis this must be rethought.
2. Failure of compliance which significantly adversely affects prophylaxis is very common.
3. The short and long-term consequences of barbiturates and newer anticonvulsants are not known.
4. Are years of anticonvulsant therapy preferable to the risk of recurrence?

The pediatric neurologists appear to believe that the answer to question 4 is yes. As a non-neurologist therapeutic nihilist my answer is no (except in unusual circumstances).

(R. Rapkin, M.D.)

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Dietary Fiber

GILBERT A. LEVEILLE, Ph.D.
East Lansing, Michigan*

Current interest regarding the role of dietary fiber stems largely from the observations of British investigators. In particular, Burkitt and Trowell^{1,2} observed that the incidence of specific types of diseases was lower in developing countries in Africa as compared to western countries. They surmised that some component of the environment must be responsible for the differences in incidence of various diseases.

They have concluded that the difference probably can be related to the decreased consumption of dietary fiber in western countries as contrasted to the very high intakes of fiber in developing countries. It must be kept in mind that these associations are correlative and do not necessarily prove cause and effect.

Fiber is provided in our diets primarily from cereals, fruits, and vegetables. There has been a marked reduction in our consumption of cereal grains and in certain fruits and vegetables. In particular, our consumption of cereals and potatoes has decreased by over 50 percent during the last 70 years.³ Accompanying this reduction has been an increase in the proportion of our total calories derived from animal products which contain no fiber.

Dietary fiber is not equivalent to crude fiber. "Crude fiber" is the material remaining after rather rigorous treatment of a food sample with acid and alkali. The residue probably reflects the cellulose and lignin content of food. "Dietary fiber," as used in this discussion, refers to the combined, undigested carbohydrates in food, and encompasses the cellulose and lignin found in crude fiber as well as hemicellulose, pectic substances, gums, and other carbohydrates which normally are not digested by man.

Disease states which may be related to a low consumption of dietary fiber include diverticular disease, cancer of the colon, atherosclerosis associated with hypercholesteremia, appendicitis, hiatal hernia, irritable bowel syndrome and hemorrhoids.^{1,2} The present discussion will consider the available evidence supporting the relationship of low fiber intake to the increased incidence of diverticular disease, cancer of the colon, and atherosclerosis.

Diverticular disease, which is virtually endemic in western societies, involves an "outpouching" or "ballooning" of the intestinal wall. The diverticula do not present a particular problem unless they become inflamed and the condition known as diverticulitis develops. Until recently the standard dietetic management of this disease has involved a low residue diet, virtually devoid of dietary fiber. Recent work by

British investigators, particularly Painter and Burkitt,⁴ has shown that the disease is treated more effectively by diets high in dietary fiber.

These observations, supported by other clinical investigators, are logical in that diverticular disease apparently develops as a consequence of having a relatively small, hard, and dry residue in the intestine which slows movement through the intestine and increases pressure within the colon. Dietary fiber prevents the increased pressure by absorbing large amounts of water resulting in a softer stool. As a consequence, transit time (i.e., the length of time required for a meal to traverse the digestive tract) is decreased and residence time (i.e., time that a material is in the intestine) is reduced.

Hypercholesteremia is one of the major risk factors in the development of atherosclerotic heart disease. Populations in developing countries have lower blood cholesterol levels than do individuals from developed countries. A major working hypothesis has been that the elevated blood cholesterol levels in developed countries result from high intake of fats, particularly animal fats. Animal products, including animal fat, increase in our diets at the expense of food items high in dietary fiber, namely cereals, fruits and vegetables—particularly cereal foods. Thus, the correlation between blood cholesterol levels and dietary fat intake is no better than that between blood cholesterol level and dietary fiber except that the latter is negative.

Several studies in both animals and humans have shown that components of dietary fiber can reduce circulating cholesterol levels. For example, it has been shown that the hypercholesteremic effect of a cholesterol-containing diet for rats could be overcome by the inclusion of barley, rolled oats or whole wheat bread in their diets.⁶ Similar studies extended to man demonstrated that the ingestion of rolled oats indeed did depress serum cholesterol levels; return to the control diet, devoid of rolled oats, resulted in an increase in the cholesterol level.⁶ The lipid component of rolled oats was partially responsible for this response, but another component in defatted rolled oats, presumably fiber, also produced a significant effect.⁶ In both animals and man it

*Reprinted with permission of *Contemporary Nutrition* 2:11 (November) 1977, a newsletter from the Nutrition Department of General Mills, Inc., Minneapolis. Dr. Leveille is with the Department of Food Science and Human Nutrition, Michigan State University, East Lansing, Michigan.

also has been shown that the addition of pectin to diets would depress blood cholesterol levels and increase the excretion of bile acids.⁷

The observed increase in bile acid excretion in animals fed pectin or other forms of dietary fiber suggests that the cholesterol depressing effect is brought about by the binding of bile acids to dietary fiber components in the intestine. Bile acids normally are secreted into the intestine in bile and serve to emulsify lipids for their digestion and absorption. The bile acids are subsequently reabsorbed and enter the bile acid pool of the body. The binding of bile acids by dietary fiber would inhibit their reabsorption and reduce the size of the bile acid pool. This presumably would increase the conversion of cholesterol to bile acids and thereby lower the circulating level of cholesterol.

This hypothesis remains to be proved, but on the basis of available evidence it is a plausible explanation. However, this would not prove necessarily that the ingestion of diets containing greater amounts of dietary fiber would reduce the incidence of cardiovascular disease.

Cancer of the colon also has been related to a low intake of dietary fiber. The available evidence demonstrates a lower incidence of cancer of the colon in countries consuming greater quantities of dietary fiber. Further, the incidence of cancer of the colon has been increasing over the past century in developed countries. The increased incidence can be correlated with the reduction in dietary fiber consumption or with the increased consumption of animal products. This does not prove that cancer of the colon is due to a reduced consumption of dietary fiber or to the greater consumption of animal fats and protein. The statistical association is merely suggestive and demands further attention.

The epidemiological evidence suggests that an environmental factor, probably diet, is related to the development of colonic cancer. For example, it has been observed that Japanese residing in Japan have a very low incidence of colonic cancer, whereas Japanese residing in Hawaii have a higher incidence; in males the incidence is virtually identical to that of white males in the U.S. This correlative evidence is impressive, but it does not prove cause and effect.

A current working hypothesis implicates some dietary residue(s) as a substrate for microorganisms in the colon. These microorganisms presumably convert the food residue to a compound(s) which, if present at a high enough concentration for an adequate period of time, can be carcinogenic. A diet high in dietary fiber could alter the composition of the microflora in the colon, resulting in an inhibition in the production of potential carcinogens; or, a diet high in

fiber might contain less of the substrate which might be converted by microbiological action to a carcinogen.

A second possibility is that dietary fiber, by decreasing the transit time of food residues through the intestine, might reduce the exposure time of the tissue to carcinogens. Thirdly, by increasing the water content in the colon, dietary fiber might function to reduce the concentration of potential carcinogens.

I have attempted to point out the current state of our knowledge with regard to the effects of dietary fiber which might relate to human health. The relationship of dietary fiber to heart disease and to cancer of the colon is not supported by experimental evidence. Hopefully, definitive evidence regarding the role of dietary fiber as it relates to these two disease entities will be forthcoming. For the moment we are faced with the question of whether, on the basis of available evidence, it is desirable to increase our consumption of dietary fiber. This is not a simple question to resolve for we have little factual information available.

One important concern of increased fiber consumption must be considered. Dietary fiber can bind other nutrients in the intestine. It is known that some indigestible components, particularly phytic acid, can bind some trace elements and in experimental animals produce a deficiency of these trace elements. This certainly must be considered as we grapple with the question of increasing the amount of dietary fiber in the American diet. The available evidence certainly is not adequate to warrant a major change in the diet of the total U.S. population; however, the need for further research is apparent.

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Donald A. Greenfield, M.D., <i>Chairman</i>	Maplewood
Harry T. Friebel, M.D., <i>Secretary</i>	Medford

Orthopedic Surgery

Stuart A. Hirsch, M.D., <i>Chairman</i>	Bridgewater
Ralph J. Cavalier, Jr., M.D., <i>Secretary</i>	Atlantic City

Otolaryngology

Frank L. Kardos, M.D., <i>Chairman</i>	Paterson
Ronald B. Low, M.D., <i>Secretary</i>	Hackensack

Pediatrics

Carl S. Ross, M.D., <i>Chairman</i>	East Orange
Stanley Karp, M.D., <i>Secretary</i>	Cinnaminson

Physical Medicine and Rehabilitation

M. Noel Jennings, M.D., <i>Chairman</i>	Long Branch
Tae-Soo Chung, M.D., <i>Secretary</i>	Dover

Plastic and Reconstructive Surgery

Richard M. Monihan, M.D., <i>Chairman</i>	Northfield
Richard B. Bloomenstein, M.D., <i>Secretary</i>	Englewood

Psychiatry

Linus B. Root, M.D., <i>Chairman</i>	Short Hills
Lawrence B. Erlich, M.D., <i>Secretary</i>	Haddonfield

Radiology

Jefferson Bastidas, M.D., <i>Chairman</i>	Livingston
Herman M. Robinson, M.D., <i>Secretary</i>	Orange

Rheumatism

Bertram D. Hurowitz, M.D., <i>Chairman</i>	Lawrenceville
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Surgery

Eugene H. Kain, M.D., <i>Chairman</i>	Pennsauken
Bruce J. Brener, M.D., <i>Secretary</i>	Millburn

Urology

Emile J. Berlet, III, M.D., <i>Chairman</i>	Hackensack
Louis I. Keeler, M.D., <i>Secretary</i>	Collingswood

Credentials

Arthur Bernstein, M.D., <i>Chairman</i>	
(<i>Secretary</i>) Ex-Officio	East Orange
John W. Nicholson, III, M.D., <i>Vice-Chairman</i>	
(1979)	Moorestown
Thaddeus Balinski, M.D. (1979)	Perth Amboy
Samuel C. Ingraham, II, M.D. (1981)	Ocean City
Roger C. Laauwe, M.D. (1980)	Wayne
Marcel A. Mersch, M.D. (1980)	Hackettstown
Lawrence B. Owen, M.D. (1981)	Woodstown

Finance and Budget

Richard E. Lang, M.D., <i>Chairman</i> (1981)	Passaic
William Greifinger, M.D., <i>Vice-Chairman</i>	
(1979)	Belleville
Harry M. Carnes, M.D. (1981)	Audubon
Edward A. Jasionowski, M.D. (1979)	Sayreville
Charles S. Krueger, M.D. (1980)	Mount Holly
James S. Todd, M.D. (1980)	Ridgewood
Rudolph C. Gering, M.D., <i>Treasurer</i>	
Ex-Officio	Pennington

Medical Defense and Insurance

Michael J. Doyle, M.D., <i>Chairman</i>	
(1979)	Neptune
Frank J. Malta, M.D., <i>Vice-Chairman</i>	
(1980)	Toms River
Irving P. Borsher, M.D. (1980)	Newark
Paul J. Hirsch, M.D. (1981)	Bridgewater
E. Arthur Kratzman, M.D. (1981)	Plainfield
William G. Kuhn, Jr., M.D. (1979)	New Brunswick
Arthur Bernstein, M.D., <i>Secretary</i>	
Ex-Officio	East Orange
John J. Crosby, Jr., M.D., <i>Consultant</i>	Jersey City
William J. D'Elia, M.D., <i>Consultant</i>	Spring Lake
Ralph J. Fioretti, M.D., <i>Consultant</i>	Rochelle Park
John D. Franzoni, M.D., <i>Consultant</i>	Trenton
Ernest C. Hillman, Jr., M.D., <i>Consultant</i>	Glen Ridge
Paul J. Kreutz, M.D., <i>Consultant</i>	Elizabeth
Henry Liss, M.D., <i>Consultant</i>	Chatham
Daniel J. O'Regan, M.D., <i>Consultant</i>	Trenton
Jesse Schulman, M.D., <i>Consultant</i>	Lakewood

Medical Education

Arthur Bernstein, M.D., <i>Chairman</i> (1980)	East Orange
Edwin W. Messey, M.D., <i>Vice-Chairman</i>	
(1981)	Willingboro
Alfred A. Alessi, M.D. (1980)	Hackensack
Robert W. Parvin, M.D. (1979)	Mount Holly
Frank C. Snope, M.D. (1979)	Piscataway
Sidney Woltz, M.D. (1981)	Union City
Steven Arvan, M.D., <i>Consultant</i>	Atlantic City
Paul J. Hirsch, M.D., <i>Consultant</i>	Bridgewater
William F. Minogue, M.D., <i>Consultant</i>	Summit
Robert S. Rigolosi, M.D., <i>Consultant</i>	Paramus
James A. Rogers, M.D., <i>Consultant</i>	Paterson
William S. Vaun, M.D., <i>Consultant</i>	Long Branch

Medical Student Loan Fund

Charles Cunningham, M.D., <i>Chairman</i>	
(1979)	Vineland
Antonio P. Battaglia, M.D. (1979)	Gibbstown
Palma E. Formica, M.D. (1981)	Old Bridge
William R. Muir, M.D. (1980)	Mount Holly
James P. Thompson, M.D. (1980)	Upper Montclair

Publication

Daniel B. Roth, M.D., <i>Chairman</i> (1979)	Teaneck
John F. Marshall, M.D., <i>Vice-Chairman</i>	
(1981)	Trenton
Julio delCastillo, M.D. (1980)	Trenton
Alfred A. Alessi, M.D., <i>President-Elect</i> , Ex-Officio	Hackensack
Arthur Bernstein, M.D., <i>Secretary</i> , Ex-Officio	East Orange
Arthur Krosnick, M.D., <i>Editor</i> , Ex-Officio	Trenton

Revision of Constitution and Bylaws

Hillel M. Ben-Asher, M.D., <i>Chairman</i>	
(1981)	Morristown
Daniel J. O'Regan, M.D., <i>Vice-Chairman</i>	
(1979)	Jersey City
Lawrence B. Owen, M.D. (1980)	Woodstown
Carl A. Restivo, M.D. (1981)	Jersey City
Arthur G. Sullivan, Jr., M.D. (1980)	Bound Brook
Charles O. Tyler, M.D. (1979)	Camden
Arthur Bernstein, M.D., <i>Secretary</i> , Ex-Officio	East Orange
John S. Madara, M.D., <i>Consultant</i>	Salem
Henry J. Mineur, M.D., <i>Consultant</i>	Cranford
Charles I. Nadel, M.D., <i>Consultant</i>	Irvington

Administrative Councils

Council on Legislation

Daniel J. O'Regan, M.D., <i>Chairman</i> (1980)	Jersey City
John D. Franzoni, M.D., <i>Vice-Chairman</i>	
(1979)	Trenton

Meyer L. Abrams, M.D. (1980)	Cherry Hill
Peter A. Beaugard, M.D. (1981)	Teaneck
Donald P. Burt, M.D. (1981)	Morristown
John J. Crosby, Jr., M.D. (1979)	Jersey City
William J. D'Elia, M.D. (1980)	Spring Lake
Leon A. Fraser, M.D. (1979)	Trenton
Samuel B. Pole, III, M.D. (1981)	Bridgeton
Ernest S. Redfield, M.D. (1979)	Woodbury
Bernard A. Rineberg, M.D. (1981)	New Brunswick
John R. Tobey, M.D. (1980)	Newark
James S. Todd, M.D., <i>Chairman</i> , <i>Board of Trustees</i> , Ex-Officio	Ridgewood

Council on Medical Services

Victor H. Boogdanian, M.D., <i>Chairman</i>	
(1980)	New Brunswick
John S. Madara, M.D., <i>Vice-Chairman</i> (1980)	Salem
Frank Campo, M.D. (1979)	Trenton
Armando F. Goracci, M.D. (1981)	Woodbury
Gustav L. Ibranyi, M.D. (1981)	Newark
Eugene H. Kain, M.D. (1979)	Pennsauken
Carl A. Restivo, M.D. (1979)	Jersey City
Robert S. Rigolosi, M.D. (1979)	Paramus
Richard H. Sharrett, M.D. (1980)	Plainfield
Charles O. Tyler, M.D. (1980)	Cherry Hill
Edwin S. Wilson, M.D. (1981)	Moorestown
Frank A. Wolf, M.D. (1981)	Phillipsburg
Alfred A. Alessi, M.D., <i>President-Elect</i> , Ex-Officio	Hackensack
Matthew E. Boylan, M.D., <i>Consultant</i>	Avon-By-The-Sea
Karl T. Franzoni, M.D., <i>Consultant</i>	Trenton
Frank M. Galio, M.D., <i>Consultant</i>	Bloomfield
Joseph A. Lepree, M.D., <i>Consultant</i>	Elizabeth
Nicholas E. Marchione, M.D., <i>Consultant</i>	Vineland
James A. Rogers, M.D., <i>Consultant</i>	Paterson

Special Committee to Council on Medical Services

Occupational Health, Workmen's Compensation, and Rehabilitation

Elmer J. Elias, M.D., <i>Chairman</i>	Trenton
Mathilda R. Vaschak, M.D., <i>Vice-Chairman</i>	North Plainfield
John W. Holdcraft, M.D.	Woodbury
Andrew G. Hudacek, M.D.	Morristown
M. Noel Jennings, M.D.	Holmdel
Matthew M. Mischinski, M.D.	Cherry Hill
Daniel J. O'Regan, M.D.	Jersey City
William D. Van Riper, M.D.	Green Pond
Ralph A. Young, M.D.	Maplewood
Joshua N. Zimskind, M.D.	Trenton
William E. Neeld, M.D., <i>Consultant</i>	Deepwater

Council on Mental Health

Harry H. Brunt, Jr., M.D., <i>Chairman</i>	
(1980)	Neptune
Farrell R. Crouse, M.D., <i>Vice-Chairman</i>	
(1979)	Woodstown
Joseph P. Cillo, M.D. (1981)	Cranford
Ralph J. Fioretti, M.D. (1980)	Rochelle Park
Alvin Friedland, M.D. (1980)	Livingston
Joseph J. Kline, M.D. (1981)	Trenton
Alan Kulick, M.D. (1979)	Vineland
Seymour E. Kuvin, M.D. (1979)	Livingston
Gerald H. Rozan, M.D. (1980)	Wayne
Nancy S. Sibert, M.D. (1981)	West Deptford
G. L. Triebenbacher, M.D. (1979)	Beach Haven
B. Ralph Wayman, M.D. (1981)	Morrisville, Pa.
Frank R. Begen, M.D., <i>Immediate Past-President</i> , Ex-Officio	Teaneck
Robert S. Albahary, M.D., <i>Consultant</i>	New Brunswick
Thomas R. Houseknecht, M.D., <i>Consultant</i>	Moorestown
J. Lloyd Morrow, M.D., <i>Consultant</i>	Passaic

Council on Public Health

Peter A. Gross, M.D., <i>Chairman</i>	
(1979)	Hackensack
Edward M. Coe, M.D., <i>Vice-Chairman</i>	
(1980)	Cranford
William M. Chase, M.D. (1979)	East Orange
Mary DiMedio, M.D. (1981)	Woodstown
Albert Ehrlich, M.D. (1979)	Fort Lee
Samuel C. Ingraham, II, M.D. (1981)	Ocean City
Patrick J. McGovern, M.D. (1981)	Jersey City
Thomas F. McLaughlin, M.D. (1979)	Metuchen
Charles J. Maloney, M.D. (1981)	Moorestown
Watson E. Neiman, M.D. (1980)	Cinnaminson
Bernard A. Rineberg (1980)	New Brunswick
Robert E. Verdon (1980)	Cliffside Park
George L. Benz, M.D., <i>First Vice-President</i>	
Ex-Officio	Newark
William J. Dougherty, M.D., <i>Consultant</i>	Trenton
Martin Goldfield, M.D., <i>Consultant for</i>	
<i>Communicable and Infectious Diseases</i>	Trenton

Special Committees to Council on Public Health

Cancer Control

Roy T. Forsberg, M.D., <i>Chairman</i>	Westfield
Sherman Garrison, M.D.	Bridgeton
Warren H. Knauer, M.D.	Hillside
George P. Koeck, M.D.	Hopatcong
Bernard J. Koven, M.D.	Englewood
Charles S. Krueger, M.D.	Mount Holly
John H. Landor, M.D.	Green Brook
Albert A. Pineda, M.D.	Clifton
Benjamin F. Rush, Jr., M.D.	Newark
Elissa J. Santore, M.D.	Irvington
Eva B. Stahl, M.D.	New Brunswick

Child Health

Glenn P. Lambert, M.D., <i>Chairman</i>	Flemington
Anthony Brickman, M.D.	Trenton
Frank Colantuono, M.D.	Teaneck
William J. Farley, M.D.	Brielle
Douglas Ford, M.D.	East Orange
Robert E. Jennings, M.D.	South Orange
Roger B. Kane, M.D.	Dover
John L. LaMar, Jr., M.D.	Salem
John McKernan, M.D.	Livingston

Conservation of Hearing and Speech

Aris M. Sophocles, M.D., <i>Chairman</i>	Trenton
Ralph L. Dicker, M.D.	Dover
Howard S. Farmer, M.D.	Princeton
Stephen Freifeld, M.D.	East Orange
Patrick Houston, M.D.	Cherry Hill
Donald J. Nalebuff, M.D.	Teaneck
Rowan C. Pearce, Jr., M.D.	Haddonfield
Robert Stern, M.D.	Mount Holly
Raymond B. Strauss, M.D.	Englewood
Albert F. Moriconi, M.D., <i>Consultant</i>	Trenton

Conservation of Vision

Jordan D. Burke, M.D., <i>Chairman</i>	Summit
Alfonse A. Cinotti, M.D.	Jersey City
Samuel Diskan, M.D.	Atlantic City
Harry T. Friebe, M.D.	Marlton
Oram R. Kline, M.D.	Camden
Samuel B. Pole, III, M.D.	Bridgeton
Ralph E. Siegel, M.D.	Perth Amboy
Ralph A. Skowron, M.D.	Cherry Hill
President and President-Elect, New Jersey Academy of Ophthalmology and Otolaryngology also are <i>Consultants</i> .	

Environmental Health

Philip J. G. Quigley, M.D., <i>Chairman</i>	Elizabeth
Seymour Charles, M.D.	Irvington

Stanley R. Lane, M.D.	Moorestown
Richard H. Musgnug, M.D.	Medford Lakes
E. Spencer Paisley, M.D.	Haddon Heights
Frank L. Rosen, M.D.	Maplewood
Owen A. Shteir, M.D.	Princeton
William I. Weiss, M.D.	Livingston
Meyer T. Weissman, M.D.	Elizabeth
Morris Joselow, Ph.D., <i>Consultant</i>	Newark

Maternal and Infant Welfare

Peter A. Beaugard, M.D., <i>Chairman</i>	Teaneck
Miles E. Drake, M.D.	Vineland
Pascal L. Federici, M.D.	Long Branch
James Fox, M.D.	Teaneck
Caterina A. Gregori, M.D.	Livingston
John T. Harrigan, M.D.	Westfield
Michelle Harrison, M.D.	Princeton
Michael S. Kreitzer, M.D.	Westfield
Thomas A. Noone, M.D.	Haddonfield
Nicholas J. Salerno, M.D.	Marlton
James P. Thompson, M.D.	Paterson
Felix H. Vann, M.D.	Tenafly
Leah Z. Ziskin, M.D., <i>Consultant</i>	Trenton
Margaret Gregory, M.D., <i>Consultant</i>	Trenton

Council on Public Relations

James A. Rogers, M.D., <i>Chairman</i> (1981)	Paterson
Frank Y. Watson, M.D., <i>Vice-Chairman</i>	
(1980)	Montclair
Frank R. Begen, M.D. (1981)	Teaneck
Milton R. Bronstein, M.D. (1979)	Edison
Andrew G. Hudacek, M.D. (1981)	Morristown
Frank J. Malta, M.D. (1980)	Toms River
Robert E. McNamara, M.D. (1979)	Elizabeth
Edwin W. Messey, M.D. (1979)	Willingboro
Gastone A. Milano, M.D. (1981)	Atlantic City
Jesse Schulman, M.D. (1980)	Lakewood
Ford C. Spangler, M.D. (1979)	Salem
B. Ralph Wayman, Jr., M.D. (1980)	Morrisville, Pa.
Augustus L. Baker, Jr., M.D., <i>2nd Vice-President</i>	
Ex-Officio	Dover
Louis G. Bosco, M.D., <i>Consultant</i>	Clifton

Special Committees

Chronically Ill and Aging

David Eckstein, M.D.	Trenton
Matthew E. Boylan, M.D.	Avon-By-The-Sea
Werner J. Hollendonner, M.D.	Trenton
Lawrence J. Mazzei, M.D.	Hackettstown
A. Gerard Peters, M.D.	Paterson

Emergency Medical Care

Jack R. Karel, M.D., <i>Chairman</i>	Hillside
R. Winfield Betts, M.D., <i>Vice-Chairman</i>	Medford
Clifford B. Blasi, M.D.	Sea Girt
John A. Flood, Jr., M.D.	Trenton
David A. Gehring, M.D.	Woodbury
Christine E. Haycock, M.D.	Newark
Dorson S. Mills, M.D.	Elmer
Kenneth A. Morrissey, M.D.	Teaneck
Daniel J. O'Regan, M.D.	Jersey City
Stephen J. Rodgers, M.D.	Alloway
Rudolph E. Schwaeble, M.D.	Mendham
Michael D. Yablonski, M.D.	Hackensack
Watson E. Neiman, M.D., <i>Consultant</i>	Cinnaminson

Impaired Physicians

Arthur McLellan, M.D., <i>Chairman</i>	Summit
Joyce M. Bailey, M.D.	Union
Lawrence F. Barnet, M.D.	Paterson
Philip Boyer, M.D.	Pennsville
Edward T. Carden, M.D.	Moorestown
Edward M. Coe, M.D.	Cranford
Thomas C. Fleming, M.D.	Montclair

Ronald I. Forster, M.D.	Short Hills
Boris G. Iovovich, M.D.	Fort Lee
Andrew J. V. Klein, M.D.	Orange
Thomas J. Liddy, M.D.	Livingston
Laurence R. Mundy, M.D.	Denville
Ward M. Schultz, M.D.	New Providence
Warren I. Brandwine, D.O., <i>Consultant</i>	Voorhees
Charles G. Carluccio, M.D., <i>Consultant</i>	West New York
Jack C. Gardiner, M.D., <i>Consultant</i>	Piscataway
Wilber F. Kell, D.O., <i>Consultant</i>	Somerdale
Philip May, M.D., <i>Consultant</i>	South Orange
Henry B. Murphree, M.D., <i>Consultant</i>	Piscataway

Long Range Planning and Development

William J. D'Elia, M.D. (1980)	
<i>Chairman</i>	Spring Lake
Alfred A. Alessi, M.D. (1980)	Hackensack
H. Oliver Brown, M.D. (1980)	Westfield
Leon C. Edwards, M.D. (1980)	Bedminster
Philip J. LoPresti, M.D. (1980)	Haddon Heights
Thomas E. Mattingly, Jr., M.D. (1980)	Mount Holly
Bernard Robins, M.D. (1980)	Springfield
Benjamin Wolfson, M.D. (1980)	Woodbury

Medicaid

Harvey J. Shwed, M.D., <i>Chairman</i>	Newark
John Alexander, M.D.	Newark
Seymour Charles, M.D.	Irvington

Medicine and Religion

Thomas H. McGlade, M.D., <i>Chairman</i>	Camden
Reynold E. Burch, M.D.	East Orange
Edmund E. Jacobitti, M.D.	Maywood
John S. Madara, M.D.	Salem
Louis McAfoos, M.D.	Cherry Hill
Watson E. Neiman, M.D.	Cinnaminson
George A. Nitshe, M.D.	Monroeville
Edward W. Verner, M.D.	Newark
Richard L. Neil, M.D., <i>Consultant</i>	Trenton

Retirement Plan for Physicians

Nicholas E. Marchione, M.D., <i>Chairman</i>	Vineland
Paul J. Kreutz, M.D.	Elizabeth
Albert F. Moriconi, M.D.	Trenton
Emanuel M. Satulsky, M.D.	Elizabeth

1978-1979 Special Committees and Liaison Representatives

Academy of Medicine of New Jersey

- (1) Board of Trustees/Liaison Committee
(Liaison requested by Academy—6/19/66)
Frank R. Begen, M.D. Teaneck
James A. Rogers, M.D. Paterson
Robert W. Parrin, M.D. Mount Holly
- (2) Post-Graduate Medical Education Study Committee
(Representative requested by Academy—11/15/64)
Arthur Bernstein, M.D., *Chairman*,
Committee on Medical Education East Orange
Edwin W. Messey, M.D., *Vice Chairman*,
Committee on Medical Education Willingboro

Aging, Children, and Youth, Auxiliary Committee on

- (Liaison requested by MSNJ's Auxiliary—11/19/72)
James A. Rogers, M.D. Paterson

American Medical Association Education Research Foundation

- (Liaison requested by AMA-10/7/51/)
Charles Cunningham, M.D., *Chairman, Committee on*
Medical Student Loan Fund Vineland

Audit Review Committee (1977-1978)

- (Appointed annually by Board to review previous
year's audit)
Armando F. Goracci, M.D., *Chairman* Woodbury
Frank Campo, M.D. Trenton
Anthony P. De Spirito, M.D. Neptune City
Myles C. Morrison, Jr., M.D. Morristown
Howard D. Slobodien, M.D. Perth Amboy
Consultants:
Rudolph C. Gering, M.D., *Treasurer* Pennington
Richard E. Lang, M.D., *Chairman, Committee on*
Finance and Budget Passaic
William Greifinger, M.D., *Vice-Chairman*,
Committee on Finance and Budget Belleville

Blindness, New Jersey Society for the Prevention of

- (Requested by the Society for the Prevention
of Blindness—3/19/78)
Jordan C. Burke, M.D., *Chairman, Committee*
on Conservation of Vision Summit

Blood Bank Association, New Jersey

(Liaison requested by New Jersey Blood Bank Association 4/25/69)

Frank Campo, M.D. Trenton

Blue Cross-Blue Shield Plans of New Jersey Permanent Committee on

(Appointment of committee requested by MSP—4/16/60)

James S. Todd, M.D., *Chairman*, Ridgewood
Board of Trustees
Charles S. Krueger, M.D., *President* Mount Holly
Mr. Vincent A. Maressa, *Executive Director* Trenton
Equal Representation from:
Medical-Surgical Plan of New Jersey
Hospital Service Plan of New Jersey
New Jersey Hospital Association

Board of Institutional Trustees, Department of Human Services

(Appointed by Governor for 8-year term)

Frank J. Hughes, M.D. (1979) Gloucester

Bureau of Investigation, Department of Law and Public Safety

(Cooperating committee requested by Department of Law and Public Safety—9/61)

Board of Trustees (Reaffirmed by Board of Trustees 5/9/78)—At the request of the State Board of Medical Examiners on 5/31/78, physicians specializing in internal medicine.)

David Flinker, M.D. Moorestown
Frank J. Malta, M.D. Toms River

Cardiovascular Advisory Panel to Director of Motor Vehicles

(Panel requested by Special Commission on Traffic Safety —9/17/61—appointed by Director of Motor Vehicles)

James G. Kehler, M.D. Woodbury

Commissioner's Medical Advisory Committee

(Requested by State Commissioner of Health—6/15/77—to assist in the diagnosis-related group concept (DRG))

Frank R. Begen, M.D. Teaneck
George L. Benz, M.D. Newark
Frank Campo, M.D. Trenton
John S. Madara, M.D. Salem
James S. Todd, M.D. Ridgewood
Frank Y. Watson, M.D. Montclair

Community Medicine Advisory Council

(MSNJ representation requested by Richard J. Cross, M.D., CMDNJ at Rutgers—12/20/70)

Arthur Bernstein, M.D. East Orange
Victor H. Boogdanian, M.D. New Brunswick

Consumer Health Education, Advisory Committee of the Office of

(College of Medicine and Dentistry of New Jersey)

Howard D. Slobodien, M.D. Perth Amboy

Crippled Children Commission, State

(Appointed by Governor for 5-year term)

Harry W. Fullerton, Jr., M.D. Carney's Point

Education, State Department of

(Liaison requested by the Assistant Commissioner of Education—9/21/58)

Glenn P. Lambert, M.D., *Chairman, Special Committee on Child Health* Flemington

Emotionally Disturbed Child, Advisory Council for the Handicapped, Department of Education

(Liaison requested by Department of Education—10/28/68)

William J. Farley, M.D. Brielle

Epilepsy, Advisory Panel to State Director of Motor Vehicles

(Established at request of Director of Motor Vehicles —7/29/66)

J. Berkeley Gordon, M.D. Rumson

Executive Committee

(Provided in the Bylaws, Chapter III (c))

Charles S. Krueger, M.D., *President* Mount Holly
(*Chairman*)
Alfred A. Alessi, M.D.,
President-Elect Hackensack
George L. Benz, M.D.,
First Vice-President Newark
Augustus L. Baker, Jr., M.D.,
Second Vice-President Dover
James S. Todd, M.D., *Chairman of the*
Board of Trustees Ridgewood
Frank R. Begen, M.D.,
Immediate Past-President Teaneck
Arthur Bernstein, M.D., *Secretary, Consultant* East Orange
Rudolph C. Gering, M.D., *Treasurer, Consultant* Pennington

Graduate Education, Task Force on

(Representation requested by CMDNJ)

James A. Rogers, M.D. Paterson

Health Care Administration Board

MSNJ Executive Committee members and Trustees (on an alphabetical, rotating basis) notified of meeting dates. (Per Board action 2/15/76)

Health Insurance Association of America

(Committee established at request of Health Insurance Council—3/24/57)

Arthur Bernstein, M.D., *Secretary* East Orange
(*Chairman*)
Charles S. Krueger, M.D., *President* Mount Holly
Alfred A. Alessi, M.D.,
President-Elect Hackensack
George L. Benz, M.D., *First*
Vice-President Newark
Augustus L. Baker, Jr., M.D., *Second*
Vice-President Dover
Mr. Vincent A. Maressa, *Executive Director* Trenton

Health Planning and Coordinating Council and/or its Review Committee, State

(Appointed by MSNJ President 1/15/78)

*George L. Benz, M.D., *Second Vice President* Newark
*Dr. Benz will serve in this capacity until he becomes President; at that time the Second Vice-President will become his replacement.

Health Professions Education Advisory Council

(Department of Higher Education)

William J. D'Elia, M.D. Spring Lake
Francis J. Pizzi, M.D. Trenton

Hospital Association, New Jersey

(Liaison established at request of New Jersey Hospital Association—12/17/67)

Alfred A. Alessi, M.D. Hackensack

Hospital Advisory Council, State Department of Health

(Appointed by the Commissioner of Health for an indefinite term)

Nicholas E. Marchione, M.D. Vineland

House Maintenance, Staff Policies and Personnel Relations

(Special Committee created by Board of Trustees—9/21/58)

Charles S. Krueger, M.D., *President* Mount Holly
(*Chairman*)
Alfred A. Alessi, M.D.,
President-Elect Hackensack

Arthur Bernstein, M.D., *Secretary* East Orange
 Rudolph C. Gering, M.D., *Treasurer* Pennington
 James S. Todd, M.D., *Chairman*,
Board of Trustees Ridgewood
 Richard E. Lang, M.D., *Chairman*,
Committee on Finance and Budget Passaic
 Mr. Vincent A. Maressa, *Executive Director* Trenton

JEMPAC, Conference Committee with

(Established at request of JEMPAC—6/25/67)

Daniel J. O'Regan, M.D., *Chairman*
Council on Legislation Jersey City
 Victor H. Boogdanian, M.D., *Chairman*
Council on Medical Services New Brunswick
 Augustus L. Baker, Jr., M.D., *Second*
Vice-President Dover

Judiciary and Bar, Conference Committee on Inter-Relations with the

(Established at invitation of Supreme Court—11/17/63)

Charles S. Krueger, M.D., *President* Mount Holly
 Alfred A. Alessi, M.D.,
President-Elect Hackensack
 George L. Benz, M.D.,
First Vice-President Newark
 Augustus L. Baker, Jr., M.D., *Second*
Vice-President Dover
 James S. Todd, M.D., *Chairman*
Board of Trustees Ridgewood
 Arthur Bernstein, M.D., *Secretary* East Orange
 Rudolph C. Gering, M.D., *Treasurer* Pennington
 Daniel J. O'Regan, M.D., *Chairman*
Council on Legislation Jersey City
 Michael J. Doyle, M.D., *Chairman, Committee on*
Medical Defense and Insurance Neptune
 William J. D'Elia, M.D. Spring Lake
 James E. George, M.D. Woodbury
 Elmer L. Grimes, M.D. Haddonfield
 Alexander D. Kovacs, M.D. Scotch Plains
 Henry R. Liss, M.D. Chatham
 Howard D. Slobodien, M.D. Perth Amboy
 Mr. Vincent A. Maressa, *Executive Director* Trenton
 Mr. Joseph C. Lucci, *Director of Medical*
and Insurance Affairs Trenton
 Equal representation from:
 Supreme Court Committee on Relations with the
 Medical Profession

Legislation

- (1) Federal Keymen (Mechanism established by MSNJ—4/4/54—
to serve as official intermediaries between MSNJ and the
Federal legislators)
15 Congressional District Keymen
1 Senatorial Keyman
- (2) State Keymen (Mechanism established by MSNJ—7/13/52)
Keymen in 15 Legislative Districts/21 Component Societies
List maintained by Council on Legislation and Jempac

Medicaid Peer Review Committee

(Established by Board of Trustees 4/19/70 at the request of the
Department of Human Services. The function of the Committee will
be to act upon inquiries and/or complaints originating either with
the administrators of the Medicaid Program or with physicians
serving under the program.)

1st District—
Nicholas A. Bertha, M.D. Hopatcong
 2nd District—
Ambrose P. Boyle, Jr., M.D. Teaneck
 3rd District—
Rudolph C. Gering, M.D. Pennington
 4th District—
Emanuel Abraham, M.D. Neptune
 5th District—
Nicholas E. Marchione, M.D. Vineland

Medical Assistants, (State of New Jersey) American Association of

(Liaison requested by Association—9/15/63)

William J. D'Elia, M.D. Spring Lake

Medical Liaison Committees

(High-level conference groups for discussion and
consideration of items of mutual interest)

Charles S. Krueger, M.D., *President* Mount Holly
 Alfred A. Alessi, M.D., *President-Elect* Hackensack
 Frank R. Begen, M.D., *Immediate*
Past-President Teaneck
 James S. Todd, M.D., *Chairman, Board*
of Trustees Ridgewood
 Mr. Vincent A. Maressa, *Executive Director* Trenton

(Where number of representatives from other organization is
larger than number of MSNJ representatives, the latter will be
increased from the Presidential Officers to equal the former.)

- (1) Medical-Dental
(Liaison requested by the Dental Society—6/10/51)
- (2) Medical-Hospital
(Liaison established by MSNJ—10/25/53)
- (3) Medical-Legal
(Liaison established by MSNJ—10/25/53)
- (4) Medical-Nursing
(Liaison established by MSNJ—4/4/54)
- (5) Medical-Osteopathic
(Liaison requested by Osteopathic Association—9/17/61)
- (6) Medical-Pharmaceutical
(Liaison established by MSNJ—7/26/53)

Medical Surgical Plan Board of Trustees

(Provided in MSP Bylaws)

Charles S. Krueger, M.D., *President* Mount Holly

Medicare Peer Review Committee

Established by Board of Trustees 12/20/70 at request of fiscal
intermediary. Committee will review and evaluate claims involving
questions of over-utilization under Medicare. Composition of com-
mittee includes six groups of three members each in the fields of
general practice, general surgery, orthopedic surgery, internal medi-
cine, ophthalmology, and urology.)

Membership Directory

(Special committee established by Board—11/19/61)

Arthur Bernstein, M.D., *Chairman* East Orange
 Matthew E. Boylan, M.D. Avon-by-the-Sea
 William Greifinger, M.D. Belleville
 Daniel B. Roth, M.D. Teaneck
 Mr. Vincent A. Maressa, *Executive Director* Trenton
 Mr. Robert H. Lambert, *Director*,
Fin. and Admin. Services Trenton

Membership Inquiry and Complaint Mechanism

(Established at the 12/10/72 Special Session of the House of
Delegates to deal more effectively with third party insurance carriers
and government medical programs as they affect the practices of the
membership.)

Membership Inquiry and Complaint Committee with Medical-Surgical Plan of New Jersey

Samuel Baum, M.D. Passaic
 Donald P. Burt, M.D. Morristown
 Arthur C. Dietrick, M.D. Mount Holly
 Karl T. Franzoni, M.D. Trenton
 James E. George, M.D., J.D. Woodbury

Membership Inquiry and Complaint Committee with Medicare

Alfred A. Alessi, M.D. Hackensack
 William H. Coleman, M.D. Trenton
 Richard H. DuPree, M.D. Woodbury
 Andrew G. Hudacek, M.D. Morristown
 Joseph W. Schauer, Jr., M.D. Farmingdale

Membership Inquiry and Complaint Committee with Medicaid

John J. Crosby, Jr., M.D. Jersey City
Michael J. Doyle, M.D. Neptune
Armando F. Goracci, M.D. Woodbury
Robert E. McNamara, M.D. Elizabeth
B. Ralph Wayman, M.D. Morrisville, Pa.

Membership Inquiry and Complaint Committee with Other Health Insurance Carriers

Melvin J. Andrews, M.D. Cherry Hill
Carl Minitti, M.D. Gibbstown
Emanuel M. Satulsky, M.D. Elizabeth
Howard D. Slobodien, M.D. Perth Amboy
Robert A. Weinstein, M.D. Newton

New Jersey College of Medicine and Dentistry, Student AMA

(Liaison requested by New Jersey Chapter—1/26/60)
Louis F. Albright, M.D. Spring Lake

New Jersey Health Sciences Group

(Membership requested by the Group 1/19/75)
Edward G. Bourns, M.D. Jamesburg
Paul J. Hirsch, M.D. Bridgewater
Bernard A. Rineberg, M.D. New Brunswick

New Jersey Health Sciences Group Legislative Affairs Committee

(Liaison requested by the Group 11/16/75)
Daniel J. O'Regan, M.D., *Chairman*
Council on Legislation Jersey City

Nutrition Council, New Jersey

(Liaison established by MSNJ—12/19/54)
Howard Jacobson, M.D. Piscataway

Parents and Teachers, New Jersey Congress of

(Liaison requested by MSNJ's Committee on Child Health—12/20/64)
William J. Farley, M.D. Brielle

Pension Plan, Special Committee on

(Established by Board—5/22/55 . . . Duties outlined in Section XIII of Pension Plan Agreement)
Richard E. Lang, M.D., *Chairman, Committee on Finance and Budget* Passaic
Charles S. Krueger, M.D., *Chairman, Special Committee on House Maintenance, Staff Policies, and Personnel Relations* Mount Holly
Rudolph C. Gering, M.D., *Treasurer* Pennington

Physicians' Assistant Program at CMDNJ—Rutgers, Advisory Committee on

(Appointed by Board of Trustees 7/17/77)
Arthur Krosnick, M.D. Trenton

Radiation Protection Commission, Consultant to New Jersey

(Nomination for appointment to Commission requested —7/18/65)
Frank Gingerelli, M.D. Hackensack

Radiation Protection Commission, Advisory Committee to New Jersey

(Two consultants in nuclear medicine requested by the Commission 11/66)
Melvin H. Freundlich, M.D. Belleville
Henry J. Powsner, M.D. Princeton
Theodore J. Stahl, M.D. New Brunswick

Rehabilitation Services, Division of Vocational

(Liaison requested by MSNJ's Committee on Rehabilitation—5/65)
Daniel J. O'Regan, M.D. Jersey City

Resolutions, Committee on Annual Meeting

Established by Board of Trustees—7/18/71—to review all resolutions in advance of the annual meeting)
James A. Rogers, M.D., *Chairman* Paterson
Frank R. Begen, M.D. Teaneck
John S. Madara, M.D. Salem

Safety Council, New Jersey State

(Provided in Council bylaws)
Charles S. Krueger, M.D., *President* Mount Holly
Elmer J. Elias, M.D., *President's Representative* Trenton

State Board of Medical Examiners

Trustees notified of meeting dates on an alphabetical, rotating basis. (Per Board action 12/15/74)

Student Association, MSNJ (Formed 7/17/77)

Mr. Leonard Bielory Elizabeth
Mr. David DeVere Belleville

Thyroid Glands, Ad Hoc Committee To Study the Management of Persons with Previously Irradiated

(Established at the request of the Radiological Society of New Jersey)
David Eckstein, M.D., *Chairman* Trenton
Alexander Crosett, M.D. Summit
Elmer Grimes, M.D. Haddonfield
Henry Kuperman, M.D. Irvington
Philip J. G. Quigley, M.D. Elizabeth

Widows and Orphans of Medical Men of New Jersey, Society for Relief of

(Liaison requested by Society—5/17/59)
Joseph R. Jehl, M.D. Clifton

DOCTORS' NOTEBOOK

Trustees' Minutes July 16, 1978

A regular meeting of the Board of Trustees was held on Sunday, July 16, 1978, at the Executive Offices, Trenton. Detailed minutes are on file with the secretary of your county medical society. A summary of significant actions follows:

Marsh and MSNJ vs. Finley and Van Ness . . . Noted that the Appellate Division of the Superior Court rendered a *per curiam* decision sustaining the position of Dr. Albert P. Marsh regarding exemption of physicians in private practice from the certificate-of-need law. The importance of this litigation was emphasized by reason of the fact that it appears this is just the beginning of an attempt to regulate the private practice of medicine. One approach is apt to be through the introduction of legislation whereby the purchase of equipment for a designated amount would place a private practitioner's office in the category of a health care facility, subject to the certificate of need. It was felt further that this was an issue of concern to the New Jersey Hospital Association, and it was agreed that the Executive Committees of MSNJ and the New Jersey Hospital Association should meet to discuss the certificate-of-need issue.

New Headquarters . . . Approved the following recommendations concerning purchase of the new MSNJ headquarters:

- (a) That the Board of Trustees authorize the officers, Legal Counsel, and staff to proceed with the application for a use variance.
- (b) That the Special Committee on House Maintenance, Staff Policies, and Personnel Relations be authorized to accept the lowest responsible bids and proceed to contract.
- (c) That the President and Secretary of MSNJ be authorized to execute all required contracts on behalf of MSNJ.

Sale of Current Headquarters . . . Approved the following recommendation concerning the sale of the current headquarters:

That the Board of Trustees approve the adoption of a resolution authorizing the President, Secretary, and Legal Counsel to proceed with the sale of the current MSNJ Headquarters at a cost of \$315,000.

New Jersey Hospital Association . . . Received as informative a report from the New Jersey Hospital Association, which included the following items:

1. Senate Bill 446, as amended, has been voted out of committee. NJHA would prefer no rate-making legislation but this bill, which establishes a Rate Commission for New Jersey, contains some items believed beneficial in the long run:
 - a. Financial needs of an institution are spelled out and are consistent with the principles adopted by NJHA.
 - b. Gifts, endowments, and fund-raising projects are excluded in the rate-making consideration.
 - c. There is an oversight provision which requires the Commission to report the progress and results of the program to the Legislature.
 - d. Rules on hearings and timeliness are to be a part of the legislation, not just regulations.
2. The Court has ruled in favor of Monmouth Medical Center in litigation concerning reimbursement by Medicaid for patients no longer in need of acute care but for whom there is no space in nursing home facilities. The case has been referred to the Supreme Court and NJHA will enter as *amicus curiae*.
3. The NJHA's Council on Professional Practices is considering recommendations regarding appointment of podiatrists to medical staffs.
4. The voluntary cost-containment program is going well and it is felt that a concerted effort by all will hold back federal legislation on this matter for several years.
5. The program of diagnostic-related groups in experimental hospitals probably will not commence before January 1, 1979.

College of Medicine and Dentistry of New Jersey . . . Received as informative a report from CMDNJ, which included

the following items:

1. *Medical Education in South Jersey*—CMDNJ would welcome a statement from MSNJ on the controversy surrounding the construction of a medical education building to house CMDNJ's South Jersey programs—commitment to RMS for a full clinical campus in affiliation with Cooper Medical Center and a new permanent single-site home for CMDNJ—New Jersey School of Osteopathic Medicine.
2. *Area Health Education Center in Camden*—CMDNJ will submit to the federal government a plan for such a center in connection with the New Jersey School of Osteopathic Medicine, funding to be provided under the Florio amendment to the health manpower act of 1976.
3. *Middlesex General Hospital/RMS Clinical Campus*—CMDNJ has complied with all dictates of the State Health Department concerning the certificate of need for construction of the new medical education teaching facility and renovation of Middlesex General Hospital, which will implement the MGH/RMS core teaching hospital agreement. Consideration is being given to the options for the future of Raritan Valley Hospital.
4. *Re equitable admissions processes*—In light of the Bakke decision, CMDNJ Board of Trustees has directed that an outside consultant be engaged to review admission processes at the six CMDNJ schools.
5. A summary of CMDNJ *Board of Trustees actions* at the May 11 and June 8 meetings was presented—copies are on file in the executive office.

Basic Medical Science Structure of Southern New Jersey . . . Considered a statement adopted by the Executive Committee of the Camden County Medical Society in opposition to a basic science facility in southern New Jersey and called for an increase in enrollment at Rutgers and New Jersey Medical Schools; accomplishment of the allopathic and osteopathic basic science

program through a basic science facility already in existence and utilization of clinical facilities in South Jersey for the third and fourth years; adherence to the original concept of shared allopathic and osteopathic endeavors; and at the minimum, before any funds are expended for another basic science facility, an independent study to look at alternatives to building another school.

... Directed that the statement be referred to the Council on Medical Services for development, in consultation with the Committee on Medical Education, of a position paper to be presented to the Board at the September meeting.

CMDNJ Administration ... Took no action on a memorandum from the Middlesex County Medical Society expressing concern over the dissension in the administration of the College of Medicine and Dentistry of New Jersey, which led to the resignation of the Dean at Rutgers Medical School, and agreed to hold the matter in abeyance until the September meeting of the Board when an update on the situation will be available.

Henry J. Austin Health Center ... Approved the following recommendations as a result of discussion concerning the need for primary care physicians assigned by the National Health Service Corporation to the Henry J. Austin Health Center in Trenton:

- (a) That the task of ascertaining the number of primary care physicians in the target area be assigned to the staff of MSNJ.
- (b) That a survey be conducted by the staff of MSNJ to determine the number of primary care physicians in the target area who now are caring for the disadvantaged; those who presently are unable or unwilling to serve disadvantaged patients because of the fee schedule presently available to them; and those who would be willing to serve if the fee schedule was similar to that now available to the Henry J. Austin Health Center. (Additional funding to be requested if necessary.)

Cooper Medical Center Ambulatory Care, Inc. ... Agreed to be involved in the matter of requests regarding projected assignments of personnel in medically underserved areas and to follow the procedure of previous Board action of referring requests to the Council on Medical Services.

Note: The above action was taken as a result of an application of the Cooper Medical Center Ambulatory Care, Inc. for personnel from the National Health Service Corporation.

Psychotropic Medication ... Approved the following recommendation from the Council on Legislation resulting from Administrative Bulletin 78-3, issued by the Division of Mental Health and Hospitals on "The Administration of Psychotropic Medication to Voluntary and Involuntary Patients." The procedure would monitor medical practice by restricting the use of psychotropic medication to provide for medical review of the treating physician's medication determination.

That the Board of Trustees express its opposition to the unlicensed practice of medicine and urge the State Board of Medical Examiners immediately to investigate and intervene. This procedure clearly presents a *prospective* danger to patients in state and county psychiatric facilities. (Italics denote word added by the Board.)

AMA Regional Meetings and/or Leadership Conferences ... Referred the matter of attendance of AMA Delegates at the AMA Regional Meetings and/or Leadership Conferences to the Treasurer and the Director of Finance and Administrative Services to determine the cost of sending representatives to both sessions.

1979 Annual Meeting ... Voted to hold the 1979 Annual meeting in Atlantic City.

Note: The President and the Executive Officer pointed out that MSNJ has a solid commitment for the 1979 Annual Meeting at the Hyatt House, Cherry Hill for May 19-22, that actual meeting plans have been made with Hyatt House personnel, and that it would be a breach of contract not to honor the commitment. The Holiday Inn/Howard Johnson hotels in Atlantic City can accommodate MSNJ's annual meeting on May 12-15 although construction of the casinos for these hotels will be in progress. It was brought to the attention of the Board that the Chairman of the Annual Meeting Committee has resigned.

... Approved a recommendation that the Chairman of the Annual Meeting Committee and the Speaker of the House be solely responsible for the activities of the convention and that the responsibility of selecting a site for the annual meeting rest with the Executive Committee.

Disputed Claims Committee ... Approved the following recommendation concerning the processing of disputed Blue Cross-Blue Shield Claims:

That the Board authorize the President of MSNJ to proceed with the appointment of the Committee and a list of reviewing consultants. (Compensation for Committee mem-

bers and consultants alike will be \$75 per meeting—paid for by Blue Cross-Blue Shield.)

Budgetary Transfers ... Authorized the appropriate recommended budgetary transfers to budget accounts that were over-expended during fiscal year 1977-1978.

Ancillary Services ... Voted to change MSNJ's position on S-279 (authorizing physicians to delegate performance of limited procedures to certified technical aides) to one of approval.

Medicaid—Substitute Resolution #22 ... Authorized the Executive Committee to meet with the Governor's staff in an attempt to achieve a practical solution, equitable to all parties, concerning payment for Medicaid patients, and tabled further action on the resolution pending the outcome of these deliberations.

Note: Substitute Resolution #22 had been referred to Legal Counsel for determination of factual and legal problems. His comments are as follows:

1. First Resolved—"... payment to the hospital out-patient services for this care ... is at least 500% greater than the payment ... in a doctor's office..."
Comment: Payments for the same services in a physician's office or in a hospital outpatient department do not produce a 500% disparity. There is no documentation to support this contention. Perhaps 100 to 250% is more acceptable.
2. Second Resolved—no factual or legal problems presented.
3. Third Resolved—"... agree to see Medicaid patients without billing Medicaid ... thus putting Medicaid of New Jersey in non-compliance with federal regulations..."
Comment: If every member of MSNJ were to comply with this resolved it would be insufficient as a matter of law to produce a determination of noncompliance with Federal Regulations. There still would be a physician base of 3600 (1000 osteopathic physicians, 1000 non-member M.D.s, 1600 residents) to treat Medicaid recipients and on a basis of pure ratios there would have to be less than 750 available physicians to make services not available.
4. Fourth Resolved—no factual or legal problems presented.

Health Care Administration Board ... Instructed the Executive Committee to appoint a physician to serve as MSNJ's representative to the monthly meetings of the Health Care Administration Board.

Note: Since they were not regular Health Care Administration Board members, trustees attending these meetings on a rotating basis have not been able to get the agenda in advance and thus be prepared to participate at the meeting.

CME Requirements . . . Directed that a reply be sent to the Ocean County Medical Society (in response to a communication indicating disapproval of the 150-hour continuing medical education requirement as a prerequisite for licensure of physicians) indicating that it is not MSNJ that is contemplating the licensure requirement, but the State Board of Medical Examiners.

Paraprofessionals . . . Directed that MSNJ's current policy statement on paraprofessionals be forwarded to the State Board of Medical Examiners, along with the necessary supporting materials, in response to that Board's request for MSNJ's comments on each of the categories of the paraprofessionals for which guidelines for services are being prepared.

Note: The Board was of the opinion that even though the Society's position continues to be opposition to the licensure of physicians' assistants the Society should continue ongoing investigations of the needs of these individuals, the problems encountered by those states currently using paraprofessionals, and whether the members would employ them should they be licensed in New Jersey.

Fee Freeze . . . Instructed the Executive Director to write to the Coalition of Southern New Jersey County Medical Societies (Atlantic, Burlington, Camden, Cape May, Cumberland, Gloucester, and Salem) cautioning against separate and unilateral activity (such as taken by the Coalition in recommending that there be no increase in physicians' fees for the next six months—already accepted by Gloucester), and suggesting that those counties comprising the southern end of New Jersey consider establishing one central executive office rather than an office for each county society.

New Jersey Health Officers' Association . . . Directed that Arthur Krosnick, M.D., be asked to participate as a panel member at the New Jersey Health Officers' Conference—"Health Screening—A Valuable Tool of Preventive Health or a Waste of Time, Money, and Resources?"—to be held in Atlantic City November 15 and 16.

Blue Shield 14/20 Program . . . Noted the following information from MSP

concerning automatic inclusion in the Series 14/20 Plan of physicians participating in the Series 500 and 750 Plans, and directed that the Middlesex County Medical Society, who protested this automatic inclusion, be notified that a reply would be forthcoming from MSP:

Agreements signed by physicians who desire to participate in the fixed fee programs of MSP specifically provide that the physicians "will perform the medical and surgical services specified in the subscription certificates issued or that may be issued by the Plan, in accordance with accepted practices in the community at the time the services are rendered and at such rates of compensation as shall be determined by the Board of Trustees of the Plan." In view of this provision there is no legal requirement that the Plan enter into separate agreements for the new fixed-fee program. Counsel for MSP concurs in this opinion.

Physicians' Assistants . . . Referred to the Ad Hoc Committee on Physicians' Assistants a letter from the Joseph W. Katz Company which expressed concern over the lack of unanimity among physicians on the issue of physicians' assistants and asked if the Board would be willing to reconsider its position.

CMDNJ Notes*

Stanley S. Bergen, Jr., M.D.
President

Interest in and awareness of child abuse and neglect have soared in recent years. The Protective Services Resource Institute is one of 16 demonstration resource projects funded through HEW's National Center on Child Abuse and Neglect. Training, technical assistance, and public awareness activities are the nucleus of the Institute's program.

Initially, training of various professionals was seen as the primary function, and in the last three years nearly 6,000 people have received some type of instruction related to child abuse and neglect (8 percent of these were physicians, 12 percent other health professionals). The training process included an in-depth needs' assessment, development of a specific curriculum to meet those needs, participation from a wide variety of experienced trainers (staff and consultants), and a thorough evaluation. Training often focused on identification of abuse and neglect, underlying causes, treatment, attitudes and

values, the law, and the role of child welfare agencies.

As Institute staff became familiar with the service delivery system, it was clear that to be useful, training had to be closely related to that system. The knowledge, skills, and enthusiasm engendered by training sessions frequently were lost when professionals returned to work settings characterized by tremendous caseloads and poorly organized service systems. Follow-up to the training in the form of technical assistance took on new importance.

In its role as a resource center, with no direct service responsibilities, the Institute was in the unique position of being able to bring together agencies involved in family and children's services, for the purpose of coordinating their efforts and improving communication. Protective services coalitions were created in a number of counties throughout the state. Other assistance efforts were directed at supporting Parents Anonymous groups, developing procedural manuals for hospitals and other institutions, examining child welfare laws, and developing guidelines for caseworkers, educators, and other professionals.

At the same time the Institute was engaged in public awareness activities, which included a monthly newsletter, in a radio series on abuse and neglect broadcast on the Rutgers Radio network, in numerous publications, and in 12 conferences covering such topics as sexual abuse of children, child neglect, and communication skills in the helping professions. The objectives of these activities were to familiarize citizens and professionals with the child abuse and neglect reporting laws, to publicize the many programs and available resources related to child abuse and neglect, and to raise significant issues. Special newsletters were published on child abuse and neglect and the family in a multicultural context, on professional education, and on organizational issues.

Over the last three years increased experience and research in the dynamics of child maltreatment have led to a new

*This month's column was written by Aaron Cohen, Acting Executive Director of the Protective Services Resource Institute, which is sponsored jointly by CMDNJ-Rutgers Medical School's Department of Pediatrics, the New Jersey State Department of Human Services, and the Rutgers Graduate School of Social Work.

emphasis on prevention activities. This is reflected in Institute work in a number of very specific areas. PSRI staff have developed and distributed child abuse and neglect curricula to schools of social work, medicine, and law. Parent effectiveness training has been conducted for various groups throughout New Jersey. Finally, PSRI is devoting an entire edition of its newsletter, the *P.S.R.I. Report*, to the issue of prevention of child abuse and neglect.

As are many other social issues, child abuse and neglect are of primary concern to a relatively small group of professionals (social workers), and of some concern to a much larger group which includes health professionals, educators, and law enforcement personnel. The Protective Services Resource Institute has addressed the needs of both groups and simultaneously has developed an information base and core of resource people readily transferable to related areas such as spouse abuse and intrafamily violence. The issues of culture, organizational approach, and prevention are relevant to these other emerging social issues. We anticipate refunding as the HEW Region II resource project for child abuse and neglect and expect to build on our considerable expertise in that area, while providing assistance in related areas, thus truly representing a resource for our sponsors as well as for the professionals and citizens of the state and the region.

Report from the Foundation

Daniel J. O'Regan, M.D.
Medical Director

The Statewide Professional Standards Review Council for New Jersey will have its third meeting this month. Organizational matters are being pursued under the guidance of Arthur Bernstein, M.D., Chairman. The Council will be responsible for many activities concerning PSRO affairs. Among these are coordination, dissemination of information, PSRO evaluation, considering appeals and sanctions, and assisting the Secretary of HEW in replacing a PSRO, should that become necessary. Area VII's PSRO has become Conditional. That means that all of New Jersey is at long last covered by Conditional PSROs. The State Council has proposed

to DHEW that the Foundation be its administrative and operating arm. We appreciate this vote of confidence on the part of the Council members.

The IPA Consortium of NJFHCE has begun its activities. James A. Rogers, M.D., our President, was elected Chairman of the Consortium. Interest in the concept of prepaid medical care continues to rise in New Jersey. Ms. Barbara Kempczinska, our Assistant Director, has been very busy in the IPA field. Dr. Richard Egdahl, of Boston, a national authority in the field, kindly has consented to assist our endeavors. His wisdom and experience are well known.

Speaking of wisdom and experience, the Foundation would be negligent not to acknowledge the many contributions of Joseph P. Donnelly, M.D. Dr. Donnelly, as you know, retired this month as President of the Medical-Surgical Plan of New Jersey. He has been a leader in medical affairs in this State since he began to practice many years ago. His knowledge of medicine and its practitioners is prodigious. He put all of these attributes to good use in the Houses of Delegates of MSNJ and AMA. Add to these his unfailing good humor and a ready wit, and you have a natural leader whose like we may not see again.

Physicians Seeking Location in New Jersey

The following physicians have written to the Executive Office of MSNJ seeking information on possible opportunities for practice in New Jersey. The information listed below has been supplied by the physician. If you are interested in any further information concerning these physicians, we suggest you make inquiries directly to them.

ADOLESCENT MEDICINE—Robert S. Smith, M.D., 39 Fairlane Drive, Wethersfield, CT 06109. Medical College of Virginia 1969. Special interest, adolescent psychiatry. Board eligible, pediatrics and psychiatry. Group, solo. Available July 1979.

AEROSPACE MEDICINE—Laurence H. Blackburn, Jr., M.D., 56 Woodcrest Lane, Doylestown, Pennsylvania 18901. Johns Hopkins University 1955. Board certified. Industrial, group, or administrative. Available.

ANESTHESIOLOGY—Arundev Dahyabhai Desai, M.D., 7-29 Hegman Ave., Apt. 17-C, Brooklyn, NY 11212. B.J. Medical College (India). Board eligible. Group, part-

nership, solo, salaried. Available.

Mahendra N. Sampat, M.D., Nassau County Medical Center, 2201 Hempstead Turnpike, East Meadow, New York 11554. Calcutta (India) 1969. Board eligible. Group, partnership, institution. Available.

Yi Shien Lin, M.D., 636 Brooklyn Avenue, Apt. 14-C, Brooklyn, New York 11203. Koahsiung (Taiwan) 1968. Board eligible. Group or partnership. Available.

Cesar A. Souza, M.D., 331 Theatre Drive, 1C14, Johnstown, PA 15904. Montevideo (South America) 1967. Board eligible. Group or solo. Available.

Alan D. Weinstock, M.D., 320 Ocean Parkway, Brooklyn, New York 11218. Albert Einstein 1974. Board eligible. Group, partnership, or institution. Available.

Anselma L. Canlas, M.D., 385 Wildrose Avenue, Bergenfield 07621. Santo Tomas (Philippines) 1969. Board certified. Group or partnership. Available January 1979.

Chien Hsin Tsai, M.D., 2327 Duke Street, Mason Gardens, Apt. F-3, Alexandria, VA 22314. Taipei (Taiwan) 1971. Board eligible. Group or partnership. Available October 1978.

CARDIOLOGY—Zouheir H. Elias, M.D., 4014 West 13 Mile Road, Apt. 11, Royal Oak, Michigan 48072. French Faculty (Lebanon) 1974. Subspecialty, internal medicine. Board certified (IM). Group, partnership. Available July 1979.

CARDIOVASCULAR DISEASES—Sae Kirl Kim, M.D., 8-C Borden Apartments, Third Avenue, Long Branch 07740. Chonnam University (Korea) 1967. Subspecialty, internal medicine. Board eligible (IM). Group, partnership. Available.

W. Bruce Fye, M.D., 307 Overbrook Road, Baltimore, Maryland 21212. Johns Hopkins 1972. Subspecialty, internal medicine. Board certified (IM). Group or institution. Available.

Anil G. Kothari, M.D., 9500 Euclid Avenue, Cleveland, Ohio 44106. Topiwala Medical School (India) 1972. Subspecialty, internal medicine. Board certified (IM). Group, partnership, institution. Available.

Michael M. Neumann, M.D., 5415 North Sheridan Road, Chicago, IL 60640. Dusseldorf (Germany) 1971. Subspecialty, internal medicine. Board certified (IM). Group or institution. Available November 1978.

DERMATOLOGY—Robert W. Gurney, M.D., 333 East Ontario Street, #4309, Chicago, Illinois 60611. Georgetown 1974. Board eligible. Group or partnership. Available.

EMERGENCY MEDICINE—Raymond P. Limansky, M.D., 950 49th Street, Apt. 4-F, Brooklyn, New York 11219. University of Barcelona 1974. Subspecialty, general practice. Solo or emergency room. Available.

Karshandas N. Kacha, M.D., 61 Bross Place, Apt. 15-A, Irvington 07111. B.J. Medical College (India) 1969. Subspecialty, family practice. Group, emergency room. Available.

ENDOCRINOLOGY—Jamshid Alizadeh, M.D., 1427 East Willow Lake Drive, NE,

Atlanta, Georgia 30329. Tehran Medical School (Iran) 1968. Subspecialty, internal medicine. Board certified (IM). Group, public or school health, institution. Available September 1978.

Frederick E. Lewis, M.D., 445 East 68th Street, Apt. 4-B, New York, New York 10021. Albany Medical College 1971. Subspecialty, internal medicine. Board certified (IM). Group, partnership, or solo. Available.

FAMILY PRACTICE—Gwendolyn D. Williams, M.D., 557 W. 141st Street, New York, New York 10031. University of Zurich 1963. Subspecialty, pathology. Board eligible (path.). Group or public health. Available.

Lawrence I. Weissman, M.D., 10 Salem Park, Elizabeth, New Jersey 07208. New York Medical College 1975. Board eligible. Group or partnership. Available.

Thomas P. Harakal, M.D., 202 Laura Drive, Danville, Pennsylvania 17821. Temple 1975. Board eligible. Group, partnership, research. Available.

Julio E. Pardave, M.D., 2650 Selwyn Avenue, Apt. 20-D, Bronx, New York 10457. San Marcos (Peru) 1973. Subspecialty, pediatrics. Board eligible, pediatrics. Group, partnership, public health. Available.

Janet Crane Vassar, M.D., 2029 Nuuanu Avenue, Honolulu, Hawaii 96817. Medical College of Pennsylvania 1977. Partnership, school health, solo. Available.

Ramzy Nasr Nabih, M.D., 126 Minges Circle, Battle Creek, Michigan 49015. Cairo (Egypt) 1947. Board eligible. Group or partnership. Available.

Scott D. Kirsch, M.D., 19250-7 Hamlin Street, Reseda, CA 91335. SUNY (Buffalo) 1971. Board eligible. Partnership, group. Available January 1979.

GASTROENTEROLOGY—Robert A. Sable, M.D., 2500 F Johnson Avenue, Apt. 15-A, Bronx, New York 10463. Einstein College of Medicine 1973. Subspecialty, internal medicine. Board certified (IM). Group, partnership. Available.

Philip J. Di Giacomo, Jr., M.D., 2108 B Crosby Street, Philadelphia, Pennsylvania 19112. Jefferson 1972. Subspecialty, internal medicine. Board certified (IM). Group, partnership. Available July 1979.

Drew P. Ronnermann, M.D., 275 Bryn Mawr Avenue, Apt. K-43, Bryn Mawr, PA 19010. NYU 1974. Subspecialty, internal medicine. Board eligible. Board certified (IM). Group or partnership. Available July 1979.

Ronald Roth, M.D., P.O. Box 8624, Academy Station, New Scotland Avenue, Albany, NY 12208. Albany Medical College 1974. Subspecialty, internal medicine. Board eligible (IM). Group, partnership, solo. Available July 1979.

David I. Reissman, M.D., 1763 Rolling Lane, Cherry Hill 08003. Albert Einstein 1974. Subspecialty, internal medicine. Board certified (IM). Group or partnership. Available July 1979.

John F. Schultheiss, M.D., Box 6, Second General Hospital, Landstuhl, West Germany. Wisconsin 1970. Subspecialty, internal

medicine. Board certified (IM). Group, partnership, or solo. Available October 1979.

GENERAL PRACTICE—Joong Wan Kim, M.D., 220 Bolling Drive, Goldsboro, NC 27530. Busan Medical School (Korea) 1961. Subspecialty, dermatology. Board eligible (family practice). Solo, group. Available February 1979.

Jaw Yan Wang, M.D., 630 West Washington Street, Suffolk, VA 23434. Kaohsiung (Taiwan) 1971. Subspecialty, emergency medicine. Any type practice. Available.

Paul L. Maitheny, M.D., 99 Pawnee Rd., Lakewood 08701. Graz (Austria) 1951. Board eligible (psychiatry). Group. Available.

GYNECOLOGY—S. Stanley Barr, M.D., 255 South 17th Street, Philadelphia, Pennsylvania 19103. Hahnemann 1933. Board certified (obstetrics & gynecology). Group or partnership. Available.

Charles I. Ware, M.D., 3325 Bayshore Boulevard, Apt. B-37, Tampa, FL 33609. University of Maryland 1948. Subspecialty, emergency medicine. Board eligible, obstetrics and gynecology. Group, partnership, emergency room. Available January 1979.

HEMATOLOGY—Jean Bello Belasco, M.D., 34 Fidelity Courts, Carrboro, North Carolina 27510. Temple University 1973. Subspecialty, pediatrics. Board eligible (pediatrics). Institution, group, or research. Available.

Mohan Singh Khurana, M.D., 6732 North Kendall Drive, Apt. C-110, Miami, FL 33156. All-India Institute (New Delhi) 1973. Subspecialty, internal medicine. Board certified (IM). Board eligible. Solo, group. Available July 1979.

INTERNAL MEDICINE—Stephen Winograd, M.D., 208 Walnut Street, Montclair 07042. NYU 1972. Subspecialty, gastroenterology. Board certified. Group, partnership, solo. Available.

Martin R. Mersky, M.D., 1722B Ferndale Avenue, Abington, Pennsylvania 19001. Jefferson 1975. Board eligible. Group, partnership, solo, institution, industrial, academic, or public health. Available.

Sang Hee Park, M.D., 102 Livermore Street, Boston, Massachusetts 02126. Catholic Medical College (Korea). Subspecialty, nephrology. Board certified (IM). Group or partnership. Available.

Barry J. Buls, M.D., 710 East Seventh Street, Brooklyn, New York 11218. New York Medical College 1975. Board eligible. Group, partnership, solo. Available.

Jameel Katmeh, M.D., Deborah Heart and Lung Center, Browns Mills 08015. Damascus (Syria) 1972. Subspecialty, cardiovascular diseases. Board eligible (cardiovascular diseases). Group or partnership. Available.

Dunthor M. Puttaswamy, M.D., 10A Southgate Apts., 272 Ward Avenue, Bordentown 08505. University Medical College, Mysore (India) 1954. Board eligible. Group, solo, or institution. Available.

Alexander D. Shimanovsky, M.D., 221 Morris Avenue, Summit 07901. Ist Medical Institute (Russia) 1971. Board eligible. Group or partnership. Available.

Drew Paul Ronnermann, M.D., 275 Bryn Mawr Avenue, Apt. K-43, Bryn Mawr, Pennsylvania 19010. New York Medical College 1974. Subspecialty, gastroenterology. Board certified. Group or partnership. Available July 1979.

Marta Stekelman, M.D., P.O. Box 900, Hightstown 08520. Bs. As. Medical School 1959. Subspecialty, gastroenterology. Board eligible. Group, partnership, solo, research, hospital-based. Available.

Renuka Kumar, M.D., 8 Valley Park South, Bethlehem, PA 18018. University of Delhi 1970. Board eligible. Group, partnership, hospital-based, solo. Available.

Edward B. Ruby, M.D., 9928 Sandy Road, Philadelphia, PA 19115. Jefferson, 1971. Subspecialty, endocrinology. Board certified (IM and endocrinology). Group or partnership. Available.

David C. Sobel, M.D., 181 Long Hill Road, Apt. 4-8, Little Falls 07424. SUNY (Downstate) 1976. Board eligible. Partnership or solo. Available July 1979.

Kim King Chan, M.D., 425 Goler House Apts., Rochester, New York 14620. Santo Tomas (Philippines). Board eligible. Group, solo, associate. Available.

Bhattacharyya Y. Linganna, M.D., 742 South Cedarhill Drive, Allentown, PA 18103. Mysore (India) 1964. Subspecialty, family practice. Solo, group, emergency room. Available July 1979.

Edward B. Laub, M.D., 25-C Durham Drive, Williamsville, New York 14221. CMDNJ 1976. Group, solo. Available July 1979.

Karkada Jayarama Upadhyaya, M.D., 18-A 250 Ann Street, Easton, PA 18042. Bangalore (India) 1973. Subspecialty, emergency medicine. Group, partnership, emergency room. Available July 1979.

Leonard I. Raifman, M.D., 3333 Henry Hudson Parkway, Apt. 2-P, Riverdale, NY 10463. Guadalajara 1972. Subspecialty, cardiovascular diseases. Board eligible. Group, partnership. Available October 1978.

Hasmukh Jariwala, M.D., 222 Westfield Avenue, Roselle Park 07204. S.S. Medical College (India) 1971. Board eligible. Group, partnership, solo, emergency room. Available.

Tsuo-pin Lin, M.D., 1945 Corlies Avenue, Neptune 07753. Kaohsiung (Taiwan) 1971. Solo, partnership, group. Available July 1979.

Jeffrey D. Stahl, M.D., 2122 Cottingham Drive, Lyndhurst, Ohio 44124. Columbia 1974. Subspecialty, gastroenterology. Board eligible. Partnership, group, solo. Available July 1979.

William L. Liao, M.D., 1945 Corlies Avenue, Neptune 07753. University of Philippines 1972. Board eligible. Group, partnership. Available July 1979.

NEOPLASTIC DISEASES—Stanley Ostrow, M.D., 9 Wychwood Court, Baltimore, MD 21209. Downstate 1974. Subspecialty, internal medicine, oncology.

Board eligible, oncology. Group or partnership. Available January 1979.

NEPHROLOGY—Prakash Ananthanarayan, M.D., 1590 Anderson Avenue, Apt. 16-D, Fort Lee 07024. Calicut (India) 1970. Subspecialty, internal medicine. Board certified (IM). Group, partnership, solo. Available.

Joseph Jyh Chung Lee, M.D., 5131 Wissioming Road, Washington, DC 20016. National Taiwan University 1971. Subspecialty, internal medicine. Board certified (IM). Group, partnership, institution. Available.

Allan A. Shook, M.D., 32 East Gravers Lane, Philadelphia, Pennsylvania 19118. NYU, Syracuse 1973. Board eligible. Group or partnership. Available.

NEUROLOGY—Riaz A. Janjua, M.D., 153 West 11th Street, New York, NY 10011. King Edward, Lahore (Pakistan) 1972. Board eligible. Group, partnership, solo, research, public health, school health. Available.

Alan J. Tuchman, M.D., 828 Talbott Road, Wright-Patterson AFB, Ohio 45433. University of Cincinnati 1972. Board eligible. Group, institution, partnership, industrial, public health, administrative. Available.

Jan J. Golnick, M.D., 4 Park Avenue, Apt. 8E, New York, NY 10016. Silesian School of Medicine (Poland) 1967. Board eligible. Group, partnership, institution. Available.

OBSTETRICS/GYNECOLOGY—William L. Schneiderman, M.D., 71 Woodside Circle, Lakeridge, Torrington, CT 06790. NYU 1974. Board eligible. Group or partnership. Available.

Iraj Nakhjavan, M.D., 122-1/2 Center Street, Ridgway, PA 15853. Tehran (Iran) 1961. Subspecialty, family practice. Solo, partnership, group. Available.

Kamrul Hasan, M.D., 18220 Lorain Avenue, Apt. 66, Cleveland, OH 44111. Dow Medical College (Pakistan) 1972. Board eligible. Group, research, partnership. Available.

Saud A. Tarawneh, M.D., 2212 Foxbourne Road, Toledo, OH 43614. Damascus (Syria) 1967. Board eligible. Solo, partnership, group. Available.

Susane L. Friedlander, M.D., 305 East 24th Street, Apt. 10-C, New York, NY 10010. NYU 1974. Board eligible. Group, partnership. Available.

Kapila M. Patel, M.D., 609 Mix Avenue, Apt. B-1, Hamden, Connecticut 06514. Baroda (India) 1968. Board eligible. Group. Available.

Richard A. Peters, M.D., 3404 Glorus Place, Wheaton, Maryland 20902. NYU 1973. Board eligible. Group, partnership, institution, administrative. Available.

Yousef S. Banoud, M.D., 162 Sunset Avenue, Farmingdale, New York 11735. Ain-Shams University (Egypt) 1965. Board eligible. Partnership, solo, group. Available.

Antonin Dostal, M.D., 64 Elmwood Avenue, Outremont, P.Q., Canada H2V 2E5. Charles University (Czechoslovakia) 1967. Board eligible. Group, partnership, solo. Available March 1979.

OCCUPATIONAL MEDICINE—Lawrence Z. Shultzaberger, M.D., 10 Pinecrest Drive, Cortland, NY 13045. Hahnemann 1951. Industrial, school health, administrative. Available.

ONCOLOGY—Jorge G. Frank, M.D., 105 Lamb Street, Travis AFB, CA 94535. Subspecialty, neoplastic diseases. Board certified (IM). Board eligible. Group, partnership. Available June 1979.

OPHTHALMOLOGY—Edward Y. Shen, M.D., 636 Brooklyn Avenue, Brooklyn, NY 11203. Kaohsiung (Taiwan) 1966. Board eligible. Any type practice. Available.

Michael J. Newton, M.D., 1370 Veteran Avenue, Apt. 119, Los Angeles CA 90024. Tufts 1971. Board eligible. Partnership, group, solo, research. Available.

Javad N. Sani, M.D., 2301 6th Street, South, Apt. 3, Arlington, VA 22204. Tehran (Iran) 1972. Board eligible. Research, group, partnership. Available.

Nissim Joseph, M.D., 110 Babcock St., Apt. 41, Brookline, MA 02146. Tel-Aviv University (Israel) 1968. Board eligible. Group, research, partnership, solo. Available.

Peter J. Cetta, M.D., 7653 Normandie Boulevard, Apt. C-33, Middleburg Heights, Ohio 44130. CMDNJ 1975. Board eligible. Group, partnership, solo. Available July 1979.

David Sheldon Hyman, M.D., 113 Chelton Parkway, Cherry Hill 08034. Med. College of Virginia 1975. Group, partnership, solo. Available July 1979.

Steven Bert Siepser, M.D., 24-203 Delaire Landing, Philadelphia, PA 19114. Downstate 1974. Group, partnership, solo. Available July 1979.

Murray H. Rothman, M.D., 67-15 102nd Street, Apt. 75, Forest Hills, NY 11375. Albert Einstein 1974. Board eligible. Group, partnership, solo, research. Available August 1979.

Glenn S. Shear, M.D., Hollandale Apts. #7-B, Clifton Park, NY 12065. Albany Medical College 1975. Group or partnership. Available July 1979.

OTORHINOLARYNGOLOGY—Naresh C. Goel, M.D., 1996A Village Green South, Providence, RI 02915. All-India Institute (India) 1973. Board eligible. Group, partnership, solo. Available December 1978.

PATHOLOGY—Vidya Deshpande, M.D., 11433 Maridosa Trail, Apt. B, Florissant, Missouri 63033. B.J. Medical College (India) 1970. Board certified. Special interest, anatomic and clinical pathology. Group. Available.

Solomon Rendler, M.D., 1482 E. 8th Street, Brooklyn, NY 11230. Wisconsin 1974. Special interest, clinical pathology. Board certified. Institution, academic, group. Available.

Balshik Min, M.D., 141 Old Short Hills Road, Apt. 11, West Orange 07052. Seoul University (Korea) 1966. Board eligible. Institution, group, partnership. Available.

Sangeeta A. Shah, M.D., 129 Brook Haven, Deridder, LA 70634. Grant Medical School (India) 1970. Board certified.

Subspecialty, clinical pathology. Partnership, solo, group, institution, industrial. Available.

PEDIATRICS—C. B. Rao, M.D., 1825 Parkside Drive, Apt. 1-2, Parkridge, Illinois 60068. Guftur Medical College (India) 1966. Board eligible. Partnership, group, solo. Available.

Andrew Stachewitsch, M.D., 96 Easton Avenue, Montreal West H4X 1L2, Quebec, Canada. Freiburg (Germany) 1955. Subspecialty, hematology. Board eligible (both). Solo, group, institution. Available.

Eric J. Flug, M.D., 813 Westwood Drive, Clayton, MO 63105. St. Louis University 1975. Board eligible. Partnership, group, institution, emergency room. Available.

Natalio Schwartz, M.D., 7660 SW 82nd Street, Apt. H-110, Miami, FL 33143. University of Chile 1972. Board certified. Institution, group, partnership. Available.

Mahrukh D. Bamji, M.D., 3091 Edwin Avenue, Apt. 4A, Fort Lee 07024. Grant Medical College (India) 1970. Board eligible. Institution, group. Available.

Shahina Qureshi, M.D., 200 Carman Avenue, Apt. 4-J, East Meadow, NY 11554. Dow (Pakistan) 1972. Subspecialty, hematology/oncology. Group, partnership. Available.

Anita C. Dy, M.D., 1947 85th Street, Brooklyn, NY 11214. University of the East (Philippines) 1967. Board certified. Solo, partnership, group. Available.

Burton Banner, M.D., 525 Ocean Parkway, Apt. 2A, Brooklyn, NY 11218. Downstate Medical Center 1974. Board eligible. Partnership, group. Available.

Paul S. Spivack, M.D., 7095 Santa Paula Circle, Buena Park, CA 90620. SUNY, Downstate 1975. Board eligible. Group, institution, partnership. Available.

Irving Zultan, M.D., 1935-3C Eastchester Road, Bronx, NY 10461. Albert Einstein 1974. Board eligible. Partnership, group, research. Available.

Abraham Nussbaum, M.D., Alpine Village, Apt. 2903, East Greenbush, NY 12061. Albany 1976. Board eligible. Group, partnership, solo. Available July 1979.

Vasanth K. Nalam, M.D., 822 Lincoln Road, Apt. 201, Bellevue, NE 68005. Andhra (India) 1969. Board certified. Group, partnership, institution. Available.

Kamran Tebbi, M.D., 1510 S. Belvoir Boulevard, South Euclid, Ohio 44121. Tehran (Iran) 1967. Subspecialty, hematology. Board certified. Group, partnership, solo, research, academic. Available October 1978.

Dolores Protagoras, M.D., 590 Fort Washington Avenue, New York, NY 10033. Wroclaw (Poland) 1965. Board certified. Group, research. Available.

PHYSICAL MEDICINE / REHABILITATION—Vidya J. Rao, M.D., 100 Livingston Avenue, Edison 08817. Sarojini-Naidu Medical College (India) 1971. Board eligible. Full-time job in hospital as physiatrist. Available.

Kyung Dok Yoon, M.D., 80-15 41st Avenue, Apt. 342, Elmhurst, NY 11373. Yonsei (Korea) 1971. Board Eligible. Institution, group, partnership. Available.

William Green, M.D., 1935-6C Eastchester Road, Bronx, NY 10461. Guadalajara 1972. Board eligible. Group, solo. Available.

PSYCHIATRY, ADOLESCENT—Robert S. Smith, M.D., 39 Fairlane Drive, Wethersfield, CT 06109. Medical College of Virginia 1969. Special interest, adolescent medicine. Board eligible, pediatrics and psychiatry. Group, solo. Available July 1979.

PSYCHIATRY—Vineet P. Kulkarni, M.D., 809 S. Marshfield, Apt. 215, Chicago, IL 60612. Topiwala (India) 1972. Board eligible. Group, partnership. Available.

Paul L. Maitheny, M.D., 99 Pawnee Rd., Lakewood 08701. Graz (Austria) 1951. Board eligible. Group. Available.

PULMONARY DISEASES—Mitchell L. Petusevsky, M.D., 5 Cragmore Road, Newton Highlands, Massachusetts 02161. NYU 1975. Board eligible (IM). Group or hospital-based. Available July 1979.

Gautam Desai, M.D., 74-38 43rd Avenue, Elmhurst, NY 11373. Baroda (India) 1970. Subspecialty, internal medicine. Board certified (IM). Board eligible. Group, solo. Available.

RADIOLOGY—Sudarshan K. Singla, M.D., 175 Ardsley Loop, Apt. 18H, Brooklyn, NY 11239. Amritsar (India) 1969. Special interest, diagnostic radiology. Board eligible, diagnostic radiology. Partnership, group. Available.

Kundan L. Gupta, M.D., 24474 Haskell, Apt. 94, Taylor, MI 48180. Amritsar (India) 1969. Board eligible. Special interest, diagnostic radiology. Solo, group. Available.

RHEUMATOLOGY—Richard K. Mastrole, M.D., 250 Cedar Ridge Drive, Apt. 509, Monroeville, PA 15146. University of Bologna (Italy) 1973. Subspecialty, internal medicine. Board eligible (IM). Group or partnership. Available July 1979.

SURGERY, CARDIOVASCULAR—Samuel C. Balderman, M.D., 5623 N. Bernard, Chicago, IL 60645. University of Illinois 1972. Subspecialty, thoracic surgery. Board certified (general surgery). Research, institution, group. Available.

Stewart Fox, Milton S. Hershey Medical Center, Hershey, PA 17033. Medical College of Virginia 1972. Subspecialty, thoracic surgery. Board eligible (general surgery). Group, partnership. Available August 1979.

Naweed Kamran Majid, M.D., Box 85, USAF Hospital, USAF APO New York 09220. King Edward (Pakistan) 1967. Subspecialty, thoracic surgery. Board certified (general surgery). Board eligible. Group, partnership. Available August 1980.

SURGERY, GENERAL—Peter R. Douglas, M.D., Two Rosewood Lane, Essex Junction, Vermont 05452. SUNY (Downstate) 1971. Board eligible. Any type practice. Available.

Alessandro Ferrero, M.D., 1915 Laird Drive, Salt Lake City, Utah 84108. Univer-

sita di Torino (Italy) 1967. Special interest in thoracic and cardiovascular surgery. Board certified. Group or partnership. Available.

Shshilkumar R. Samant, M.D., Texas Heart Institute, P.O. Box 20269, Houston, TX 77025. Seth G. S. Medical College (India) 1970. Special interest, thoracic surgery. Board eligible. Any type practice. Available.

Simon B. Santos, M.D., 8720 Chestnut Circle, Apt. 4, Kansas City, MO 64131. Santo Domingo (Dominican Republic) 1972. Board eligible. Partnership, group. Available.

Rao V. Daluvoy, M.D., 950 49th Street, Apt. 9A, Brooklyn, NY 11219. Guntur (India) 1965. Board eligible. Group, partnership, solo. Available.

Anthony R. Bescher, 51 Parkview Court, Lancaster, NY 14086. Jefferson 1971. Board eligible. Group, partnership. Available.

Fitzclarence Griffith, M.D., 17310 Whitcomb, Detroit MI 48235. Univ. of West Indies (Jamaica) 1971. Subspecialty, general practice. Board eligible. Partnership, group, public health. Available.

Frank P. Gudicello, M.D., 331B Third Avenue, Long Branch 07740. University of Bologna (Italy) 1974. Board eligible. Solo, partnership, group. Available.

Carlos A. Medina, M.D., 787 Chambord Circle, Marion, OH 43302. National University (Bogota) 1971. Board eligible. Subspecialty, emergency medicine. Group, emergency room. Available.

Kyum Tak Kim, M.D., 501 Sixth Street, Apt. 10C, Brooklyn, NY 11215. Seoul (Korea) 1968. Board eligible. Partnership, solo, group. Available.

Amelito P. Canlas, M.D., 385 Wildrose Avenue, Bergenfield 07621. University of Santo Tomas (Philippines) 1971. Board eligible. Group, partnership, solo. Available.

Kadankavil H. Joseph, M.D., 4410 Oglethorpe Street, Apt. #504, Hyattsville, MD 20781. Trivandrum (India) 1970. Subspecialty, abdominal surgery. Board eligible. Group, partnership, research. Available.

Jose P. Arias, M.D., 42-55 Colden Street, Apt. 12-B, Flushing, NY 11355. Univ. of Buenos Aires (Argentina) 1968. Board eligible. Group, partnership, solo. Available December 1978.

Larry Alan Scher, M.D., 44 Lindsley Place, Irvington 07111. Med. College of Wisconsin 1973. Board eligible. Group, partnership. Available July 1979.

Marc David Rudich, M.D., Quarters 131-EE, Warren AFB, WY 82001. Albany Medical College 1971. Subspecialty, cardiovascular surgery. Board certified. Group, partnership, solo, institutional. Available June 1979.

Marc Howard Gertner, M.D., 2201 Pennsylvania Avenue, Apt. 407, Philadelphia, PA 19130. Ohio State 1973. Group, partnership. Available July 1979.

Virgilio S. Ipapo, M.D., 5 Bloomingdale Drive, Apt. 103, South Somerville 08876. Santo Tomas (Philippines) 1971. Board eligible. Group, partnership, institutional.

Available June 1979.

Marcel Gardere, M.D., 12 Whitehall Avenue, Edison 08817. Faculte de Med., Haiti 1957. Subspecialty, general practice. Board eligible. Solo, partnership, group, emergency room. Available July 1979.

Rodolfo M. De Ocera, M.D., St. Mary Medical Building, Suite 111, Newtown, Langhorne, PA 19047. Far Eastern University (Philippines) 1961. Subspecialty, general practice. Board eligible. Solo, partnership, group. Available February 1979.

SURGERY, ORTHOPEDIC—Michael G. Dolin, M.D., 100 Avenue P, Brooklyn, NY 11204. New York Medical College 1970. Board eligible. Group, partnership. Available September 1978.

Mohamed Khalafalla Nour, M.D., 237 Fairhaven Boulevard, Woodbury, NY 11797. Cairo (Egypt) 1959. Board eligible. Solo. Available.

Robert B. West, M.D., 8 Louise Lane, Tenaflly 07670. Columbia 1973. Board eligible. Group, partnership. Available.

Ralph E. Sweeney, Jr., M.D., 9540 Indian Meadows, St. Louis, MO 63132. Georgetown 1973. Any type practice. Available August 1979.

SURGERY, THORACIC—Imad F. Tabry, M.D., 1200 4th Street, NW, Rochester, MN 55901. French School of Medicine (Lebanon) 1970. Board eligible. Board certified (general surgery). Research, partnership, group. Available.

James R. K. Condon, M.D., 498 Turner Loop, Fort Campbell, KY 42223. Albany 1968. Subspecialty, cardiovascular surgery. Board certified (general surgery). Board eligible. Group, partnership, research. Available July 1979.

SURGERY, UROLOGICAL—Jorge A. Saborio, M.D., 30-43 69th Street, Woodside, NY 11377. National, Leon (Nicaragua) 1970. Board eligible. Group, partnership, solo. Available.

Marvin L. Stein, M.D., 3801 Hudson Manor Terrace, Apt. 5L, Riverdale, NY 10463. Board eligible. Group, partnership, solo. Available.

Paul F. Low, M.D., 128-4 Kirkbride Road, Voorhees 08043. CMDNJ 1973. Board eligible. Partnership, group, solo. Available.

Larry E. Goldstein, M.D., 552 Rossmore Road, Richmond, VA 23225. Jefferson 1973. Board eligible. Partnership, solo, group. Available.

Joel S. Cohen, M.D., 3880 La Jolla Village Drive, La Jolla, CA 92037. Guadalajara 1972. Board eligible. Partnership, group, solo. Available.

Satish A. Dhagat, M.D., 1 Liberty Street, Apt. C-12, Little Ferry 07643. B.J. Medical College (India) 1966. Board eligible. Group, partnership. Available.

Gerald A. Goldman, M.D., 2913 Willowood Drive, Erie, Pennsylvania. Guadalajara 1972. Board eligible. Association leading to partnership. Available July 1979.

Joseph H. Kler Medical Philatelist

Raised on a Wisconsin farm, Joseph H. Kler was educated at the University of Wisconsin, the Medical School and Postgraduate School of Medicine at the University of Pennsylvania, and the Universities of Vienna and Oxford, England, where he was trained in "EENT." But, it is his expertise as a medical philatelist which gained national and international acclaim for Dr. Kler.

He is the author of a book, *Medicine on Stamps*, and of the *Medical Tribune* column of the same name. Dr. Kler's introduction to his book describes lucidly his philosophy about history, stamps, and medicine:

"Stamps of all nations offer a visual record of the progress of mankind. They portray the men and events which have contributed to the growth of civilization and the betterment of human life. As a physician interested in the history of man, I have developed a deep interest in stamps which record the history of medicine. Over the years, I have searched widely for these stamps, researched the subjects portrayed, and organized a collection which traces the history of medicine from the dawn of civilization to the present. This album represents some highlights of that collection, which now fills many volumes.

"To record the course of medical history through postage stamps has been a fascinating undertaking. The story begins with the first practitioner of the healing art—the individual human being in his struggle for self-preservation. It is taken up by the medicine man of primitive tribes, and continues with the rise and fall of the Egyptian, Greek, Roman, and Arabian civilizations. Medical history struggled through the superstitions and mysticism which dominated the Middle Ages and then began to flourish during the Renaissance, when

concern for man's life on earth and the soundness of his body and spirit—a view reminiscent of ancient Greece—was reborn.

"Scientific progress, the expansion of man's knowledge of disease and his ever-growing ability to alleviate suffering continued during the next four centuries. With each new discovery, the frontiers of knowledge were advanced, and today the legions of medical science steadily are attacking the remaining citadels of disease. There are more physicians and medical researchers alive and working toward the conquest of illness today than have lived in all the preceding history of man. One only can speculate with delight about the stamps which will be issued in the next fifty years as scientists solve some of the remaining mysteries of disease and discover new means to cure and prevent them.

"I take great personal pride in being a member of the medical profession and I offer this work to all the dedicated men—past, present, and future—whose efforts are devoted to the common cause of improving the quality of man's life."*

Joseph Kler became interested in stamps close to four decades ago and over the years, through great effort and his world travels, compiled a remarkable treasure of stamps with medical themes. He donated this collection of 16,000 stamps in 44 volumes to the Cardinal Spellman Philatelic Museum of Regis College, of which he is a founder.

Dr. Kler's medical accomplishments and community service never lagged despite his devotion to this avocation. Fellowships in the American Academy of Ophthalmology and Otolaryngology and in the American College of Surgeons were straddled by his past-presidency of the Middlesex County Medical Society and the Middlesex General Hospital Medical Staff, and membership in the New Jersey Academy of Ophthalmology and Otolaryngology.

He is an honorary trustee of the Eye Institute of New Jersey and a trustee of the New Jersey Commission for the Blind and Visually Impaired. He also was chairman of the Public Relations Committee of the Medical Society of New Jersey from 1936 to 1942. He was a 1978 recipient of MSNJ's Golden Merit Award. Dr. Kler prizes membership in the American Topical Association and its Medical Subjects Unit (Stamps) and the Royal Philatelic Society. Frequently he has been honored for his medical stamps by grand awards at stamp shows. Most recently he received a gold medal award for his medical stamp exhibit at the Nationalist China International Stamp Show in Taipei.

In addition to his stamps, Dr. Kler has collected silver and pewter and contributed these for national display. His pewter exhibit is on permanent loan at the Smithsonian Institutions. The Special Bicentennial Exhibit of the Smithsonian Institutions includes Dr. Kler's pewter flagon by John Christian Heine and a silver baptismal cup by Paul Revere, which the patriot made for Governor Winslow of the Colony of Massachusetts. Several of his silver articles were included in the New Jersey "Pulse of the People" Bicentennial Exhibit.

Dr. Kler was accorded an Honorary Award by the Freedoms Foundation and twice was given the Rotary Club of New Brunswick Achievement Award.

Joseph H. Kler is a most unusual physician, collector, compassionate citizen, medical historian, and philanthropist.

We must echo Dr. Kler's own words when we say that we New Jersey physicians take great personal pride that *he* is a member of the medical profession and of the Medical Society of New Jersey.

A. Krosnick, M.D.

*Kler JH: *Medicine on Stamps*. New York, Minkus Publications, 1969.

CME INFORMATION

Sports Medicine Series

The Orthopedic Section, Division of Sports Medicine, New Jersey Medical School, CMDNJ, has announced the following Distinguished Guest Lecturer Series in Sports Medicine. The first program—on football injuries—was held on September 7. Additional scheduling is as follows:

September 21—Present Status Sports Medicine: Here and Abroad
October 5—What the Athletic Commission Does for the Boxer
October 19—Head Injuries in Contact Sports
November 9—Life Clinic—Fitness and Exercise
November 16—Medical Aspects of Soccer
December 7—Writing Your Clinical Paper

Lectures will be held at 7 p.m. in Room B-610 of the Medical Science Building, 100 Bergen Street, Newark. Following each presentation there will be a half-hour question and answer period. There is no fee. For information please communicate with Mrs. Anne Stephans at the College—(201) 456-5350.

Energy Seminar

On September 23, under the sponsorship of the New Jersey Medical Women's Association, the Academy of Medicine, and the Bergen and Passaic County Medical Societies, a half-day seminar on energy and its impact on the environment will convene at 8:30 a.m. in the auditorium of Hoffmann-LaRoche in Nutley. The program is designed to augment the physician's knowledge of energy resources as they relate to public health and the environment. There will be guest speakers from the Princeton University Plasma Physics Laboratory, the University of Pennsylvania School of Medicine, the University of Detroit, and the Public Service Electric and Gas Company of New Jersey. Four credits will be awarded in Category I of the AMA Physician's Recognition Award. Registration fee is \$10. For information please communicate with the Bergen

County Medical Society, 170 Main Street, Hackensack 07601—(201) 489-3140.

Abdominal Laparoscopy Course

On Wednesday, October 25, the Delaware Valley Society for Gastrointestinal Endoscopy is sponsoring an AMA Category I, four and a half credit-hour course, "Abdominal Laparoscopy in Diagnosis and Management of Abdominal Disease," at the Philadelphia County Medical Society, 2100 Spring Garden Street, Philadelphia. The program will be conducted by faculty from medical centers in Pennsylvania, New York, Maryland, and Washington, and will focus on the value of laparoscopy in clinical diagnosis; instrumentation and techniques; indications, contraindications and complications; and laparoscopic pathologic findings and their interpretation. Registration fee is \$40; for residents, interns and Fellows the charge is \$10. For further information, please communicate with Barbara B. Frank, M.D., Crozer-Chester Medical Center, 15th and Upland Avenue, Upland, Chester, Pa. 19013.

Life and Death Conference

A two-day conference on "Life, Death, and Infinity" will be held on October 25 and 26 at the Sun Center, Chester Township, Pennsylvania. Sponsored by the Crozer-Chester Medical Center's Department of Respiratory Therapy and the Delchester Regional Health Education Consortium, the program is geared to physicians, nurses, respiratory therapists, social workers, and clergymen. The principal speaker will be Elisabeth Kubler-Ross, M.D., renowned consultant on the care of dying patients and their families. The second day will be devoted to workshops on bereavement, brain death, children with terminal diseases, hospices, legal

concerns, stress, suicide, and others. The two-day tuition is \$100 (\$50 for students); the fee for the general session (first day) is \$60 and \$40 for the workshops; the charge for students is \$30 and \$20 respectively. For information, please communicate with the Department of Respiratory Therapy, Crozer-Chester Medical Center, 15th and Upland Avenue, Upland, Chester, Pennsylvania 19013—(215) 874-9611, extension 317.

Loeser Memorial Lecture

The annual Lewis H. Loeser Memorial Lecture will be presented at 8 p.m. on Wednesday, November 1st at the South Orange Junior High School, North Ridgewood Road, South Orange. The topic is "Brief Psychotherapy: Treatment of Choice or Expediency?" and the speaker is Peter E. Sifneos, M.D., Professor of Psychiatry at Harvard Medical School. Sponsors of the program are the New Jersey Psychiatric Association; the New Jersey Psychological Association; the National Association of Social Workers, New Jersey chapter; the New Jersey State Nurses' Association; the Department of Psychiatry and Mental Health Science, New Jersey Medical School; and the Mental Health Association of Essex County. There is no fee and two credit hours will be allowed in Category I of the AMA Physician's Recognition Award. For additional information, please communicate with Ms. Barbara Schiller, Mental Health Association of Essex County, 424 Main Street, East Orange 07018—(201) 677-1540.

Seminar on Head and Neck Tumors

The Sixth W. Franklin Keim Memorial Seminar on head and neck tumors will be held November 9 through 11 at the New Jersey Medical School in Newark under the sponsorship of the school and the Newark Eye and Ear Infirmary. Some of the topics to be considered are tumor immunology, pathology of head

and neck tumors, radiotherapy, surgery, and rehabilitation. Question and answer periods will be held after each presentation, and there will be group discussions at the luncheon tables. Tuition is \$150 for practicing physicians and \$50 for residents. The program is approved for 18 hours in Category I of the AMA Physician's Recognition Award. For further information please communicate with Dr. Ki Y. Han, Newark Eye Infirmary, 15 South 9th Street, Newark 07107.

**Joint Session on
Cardiovascular Diseases
and Contemporary
Medicine**

From January 14 to 19, 1979, at Caesar's Palace in Las Vegas, the International Congress on Cardiovascular Diseases will meet jointly with the American Society of Contemporary Medicine and Surgery. The sessions will be chaired by Doctors Michael DeBakey, Eliot Corday, and Norman Kaplan. Speakers

from Europe, Japan, Israel, South America, and the United States will discuss cardiovascular surgery, cardiovascular diseases, and hypertension. Seminars will be conducted in oncology, nutrition, and rheumatology. Forty credit hours will be awarded in Category I of the AMA Physician's Recognition Award. For additional information please communicate with Rutledge W. Howard, M.D., CME Director, American Society of Contemporary Medicine and Surgery, 6 North Michigan Avenue, Chicago 60602.

CME CALENDAR

Sept.			13 Endocrine Conferences			Richmond Ave., Mount Holly		
11	Medical Preoperative Evaluation of Surgical Patients		20	3:30-5 p.m.—Rotating between Newark, Beth Israel Medical Center, Martland, and East Orange VA Hospitals	(AMNJ)	(Burlington County Medical Society, AMNJ and AAFP)		
14	SMA-12: Use and Interpretations		27			14	Case Presentations and Guest Speakers	
18	Liver and Thyroid Function Testing						7:30-9:30 p.m.—Location to be announced	
21	Tracheostomy and ENT Emergencies		13	Grand Rounds and Case Presentations			(New Jersey Institute of Ultrasound in Medicine and AMNJ)	
25	Pharmacologic Principles		20	2-4 p.m.—Rotating between Martland, Newark Beth Israel, St. Michael's, St. Joseph's Hospitals and Jersey City Medical Center	(CMDNJ and AMNJ)	14	The Middle Age Period	
28	Review of Digestive Physiology		27			21	Vertigo ENG in Psychiatry	
	5 p.m.—St. Francis Medical Center, Trenton					28	Sleep Disorders	
	(St. Francis Medical Center)		13	Burns, Current Treatment			12 noon-1 p.m.—Carrier Foundation, Belle Mead	
11	Neuroscience Conferences		20	Congestive Heart Failure			(The Carrier Foundation)	
18	11:30 a.m.-12:30 p.m.—Bergen Pines		27	Emergency Care		14	Grand Rounds and Case Presentations	
27	County Hospital, Paramus			10:30-12 noon—St. Mary's Hospital, Passaic	(St. Mary's Hospital and AMNJ)	21	4-5 p.m.—Martland Hospital, Newark	
	(Bergen Pines County Hospital and AMNJ)		13	Diagnosis and Treatment of Depression		28	(CMDNJ and AMNJ)	
12	Allergy		20	C.P.R. for Physicians		14	Psychiatric Lecture Series	
19	Proper Use of Antibiotics		27	Radiology-Pathology Conference		21	11 a.m.-12 noon—Greystone Park	
26	Dermatology			11:30 a.m.-1:30 p.m.—Rahway Hospital	(Rahway Hospital and AAFP)	28	Psychiatric Hospital	
	11 a.m.-12 noon—Greystone Park Psychiatric Hospital		13	Chronic Obstruction Pulmonary Disorders			(Greystone Park Psychiatric Hospital and AMNJ)	
	(Greystone Park Psychiatric Hospital and AMNJ)		20	Arthritis		14	Cardiology Conferences	
12	Surgical Lecture—Motor Disorders of the Esophagus		27	Hypertension		21	2:15-4:15 p.m.—Deborah Heart and Lung Center, Browns Mills	
	5-6 p.m.—Rutgers Medical School, Piscataway			1-3 p.m.—Christ Hospital, Jersey City	(Christ Hospital and AMNJ)	28	(Deborah Heart and Lung Center and AMNJ)	
	(CMDNJ and AMNJ)		13	Medical Aspects of Psychosomatic Illness—Part I		14	Basic Life Support Training Course	
12	Seminar on Law and Psychiatry		27	Part II		18	7-10 p.m.—Fair Lawn Memorial	
19	3:30-5:30 p.m.—Rutgers Law School, Newark			3:15-4:15 p.m.—Fair Oaks Hospital, Summit	(Fair Oaks Hospital and AMNJ)	25	Hospital	
26	(Rutgers University Law School and AMNJ)		13	Cardiology Conferences			(Fair Lawn Memorial Hospital and AMNJ)	
				4-6 p.m.—Rutgers Medical School, Piscataway	(CMDNJ, Somerset County Heart Association and AMNJ)	15	Psychiatric Lecture Series	
13	Course for Psychiatrists—Semester I		14	Prophylactic Use of Antibiotics		22	1:30-5 p.m.—Trenton Psychiatric	
20	8-10 p.m.—Hackensack Hospital			8-9 p.m.—Mount Holly Center, 62		29	Hospital	
27	(NJ Psychoanalytic Society and AMNJ)						(Trenton Psychiatric Hospital and AMNJ)	
13	Advances in Medicine					15	Cardiac Symptoms and Arrhythmias	
20	9:30-11 a.m.—Bergen Pines County					17	Cherry Hill Hyatt House, Cherry Hill	
27	Hospital, Paramus						(International Medical Education Corporation and AAFP)	
	(Bergen Pines County Hospital and AMNJ)							

- 15 **Symbol Process in Symbol Formation**
8:30-10:30 p.m.—Hackensack Hospital
(*New Jersey Psychoanalytic Society and AMNJ*)
- 15 **Heart Disease in the Neonate**
8:15 a.m.-10:30 a.m.—Overlook Hospital, Summit
(*Overlook Hospital and AMNJ*)
- 16 **Urology for the Non-Urologist**
9 a.m.-4:40 p.m.
- 17 **9 a.m.-1 p.m.—Rutgers Medical School, Piscataway**
(*CMDNJ, AMNJ and AAFP*)
- 19 **Fluid and Electrolyte Imbalance**
11:30 a.m.-12:30 p.m.—St. Mary's Hospital, Orange
(*St. Mary's Hospital and AMNJ*)
- 19 **Proper Use of Antibiotics**
8:30-9:30 p.m.—Omar's Restaurant, Saddle River Rd., Fair Lawn
(*Fair Lawn Memorial Hospital and AMNJ*)
- 19 **Sudden Infant Death Syndrome**
7-9 p.m.—Martland Hospital, Newark
(*NJ Chapter AAP, Child and Maternal Health Div., NJ Dept. of Health, and AMNJ*)
- 20 **Surgical Management of Sports-Related Injuries**
St. Francis Medical Center, Trenton
(*St. Francis Medical Center*)
- 20 **Death and Dying**
27 7-9 p.m.—St. Joseph's Hospital and Medical Center, Paterson
(*Passaic Valley Hospital Social Service Association and AMNJ*)
- 20 **Life and Death Decisions**
1-3 p.m.—Hoffmann-La Roche, Inc., Nutley
(*AMNJ*)
- 20 **Recent Advances in Medical Oncology**
27 **Risk Factors in Cancer**
9-11 a.m.—Middlesex General Hospital, New Brunswick
(*Middlesex General Hospital, AMNJ and AAFP*)
- 20 **Colon and Rectal Cancer**
1-2 p.m.—Trenton Psychiatric Hospital
(*Trenton Psychiatric Hospital and AMNJ*)
- 20 **Radiotherapy Section Dinner Meeting**
6:30 p.m.—The Manor, West Orange
(*AMNJ*)
- 20 **Geriatrics Syndromes Outpatient RX**
1-3 p.m.—Ancora Psychiatric Hospital Hammonton
(*Ancora Psychiatric Hospital and AMNJ*)
- 21 **The Acute Abdomen in the Newborn**
7:15-10:15 p.m.—Hospital Center at Orange
(*Diagnostic Radiology Section for Northern New Jersey and AMNJ*)
- 22 **Diagnostic and Therapeutic Problems in Orthopedics**
7:30-9 a.m.—Alexian Brothers Hospital, Elizabeth
(*Alexian Brothers Hospital*)
- 22 **Anesthesia in the High-Risk Patient**
8-9:30 a.m.—Chilton Memorial Hospital, Pompton Plains
(*Chilton Memorial Hospital and AMNJ*)
- 23 **Energy Seminar**
9 a.m.-1 p.m.—Hoffmann-La Roche, Nutley
(*NJ Medical Women's Association, Bergen and Passaic County Medical Societies and AMNJ*)
- 23 **Critical Care Management (Symposium)**
No time given—Saint Barnabas Medical Center, Livingston
(*Saint Barnabas Medical Center and AAFP*)
- 26 **Surgical Repair of Cleft Lip and Palate**
8-10 p.m.—Englewood Club, Englewood
(*Englewood Surgical Society and AMNJ*)
- 27 **Drug Addiction**
2-3 p.m.—Ancora Psychiatric Hospital
(*Ancora Psychiatric Hospital and AMNJ*)
- 27 **Advances in Nephrology in 1978**
8:30 a.m.-2:30 p.m.—Helene Fuld Medical Center, Trenton
(*Helene Fuld Medical Center, Nephrology Society of New Jersey, and AMNJ*)
- 27 **Cardiac Grand Rounds**
3-4:30 p.m.—New Jersey Medical School, Newark
(*American Heart Association, NJ Affiliate, and AMNJ*)
- 27 **18th Annual Symposium**
Aging—Ourselves Tomorrow
9:15 a.m.-5:30 p.m.—Carrier Foundation, Belle Mead
(*Carrier Foundation and AMNJ*)
- 27 **Life Threatening Dermatoses**
9 a.m.-5 p.m.—Englewood Hospital
(*Englewood Hospital and AMNJ*)
- 27 **Neuropathology Conferences**
8-9:15 a.m.—New Jersey Medical School, Newark
(*CMDNJ and AMNJ*)
- 27 **Preventive Medicine in the Elderly**
1-2 p.m.—VA Hospital, Lyons
(*VA Hospital and AMNJ*)
- 29 **The Practicing Physician's Role in the**
30 **Management of the Neurologically Impaired**
9 a.m.-5:15 p.m.—Holiday Inn, Toms River
(*Garden State Rehabilitation Hospital, The Center to Promote Health Care Studies, AMNJ, and AAFP*)
- 30 **Critical Care Management (Workshop)**
No time given—Saint Barnabas Medical Center, Livingston
(*Saint Barnabas Medical Center and AAFP*)
- Oct.
2 **Resistance to Change in a Narcissistic Man**
8-10 p.m.—9 Marquette Rd., Upper Montclair
(*Essex Psychiatric Seminar and AMNJ*)
- 2 **Psychiatric Aspects of Surgery and Trauma**
5 p.m.—St. Francis Medical Center, Trenton
(*St. Francis Medical Center*)
- 2 **Neuroscience Conferences**
16 11:30 a.m.-12:30 p.m.—Bergen Pines County Hospital, Paramus
(*Bergen Pines County Hospital and AMNJ*)
- 23 **3 Lecture Series in Otolaryngology**
8-9 a.m.—Garden State Community Hospital, Marlton
(*Garden State Community Hospital and AMNJ*)
- 3 **Seminar on Law and Psychiatry**
10 3:30-5:30 p.m.—Rutgers Law School, Newark
(*Rutgers University Law School and AMNJ*)
- 31 **3 Proper Use of Blood Gases**
8-9 p.m.—Burdette Tomlin Memorial Hospital, Cape May Court House
(*Burdette Tomlin Memorial Hospital and AMNJ*)
- 3 **Complications of Vascular Surgery**
5-6 p.m.—Rutgers Medical School, Piscataway
(*CMDNJ and AMNJ*)
- 3 **Clinical/Histopathological Overview of**
7 **Obstetrics/Gynecology**
Begins Oct. 3-9 a.m.—Waldorf Astoria, New York
(*St. Barnabas Medical Center and AMNJ*)
- 4 **Continuing Education in Psychiatry**
11 1-3 p.m.—Bergen Pines County Hospital
(*Bergen Pines Hospital and AMNJ*)
- 18 **25 Clinical Pathology Grand Rounds**
11 12 noon-1 p.m.—New Jersey Medical School, Newark
(*CMDNJ and AMNJ*)
- 4 **Grand Rounds and Case Presentations**
11 2-4 p.m.—Rotating between Martland, Newark Beth Israel, St. Michael's, St. Joseph's Hospitals and Jersey City Medical Centers
(*CMDNJ and AMNJ*)
- 4 **Bone Scanning**
11 **Recurrent Urinary Tract Infections in Older Patients**
18 **Treatment of Uremia**
25 **Radiology-Pathology Conference**
11:30 a.m.-1:30 p.m.—Rahway Hospital
(*Rahway Hospital and AAFP*)
- 4 **Pre-Hospital Coronary Care**
18 **Granulomatous Diseases of the Bowel**
25 **Cryosurgery**
1-3 p.m.—Christ Hospital, Jersey City
(*Christ Hospital and AMNJ*)
- 4 **Medical Grand Rounds**
11:30 a.m.—Rotates between Newark Beth Israel Medical Center, Martland, and East Orange VA Hospitals
(*AMNJ*)
- 4 **Environmental Cancer In New Jersey, 1978**
18 **Masks of Depression**
25 **Sarcoidosis and other Granulomatous Disorders**
9-11 a.m.—Middlesex General Hospital, New Brunswick
(*Middlesex General Hospital, AMNJ, and AAFP*)
- 4 **Lectures in Obstetrics and Gynecology**
8-10 p.m.—Location varies
(*CMDNJ and AMNJ*)
- 4 **Cardiology: Pre-Hospital Coronary Care**
1-3 p.m.—Christ Hospital, Jersey City
(*Christ Hospital and AMNJ*)
- 4 **Colitis: Diagnosis and Management**
10:30 a.m.-12 noon—St. Mary's Hospital, Passaic
(*St. Mary's Hospital and AMNJ*)
- 4 **Geriatrics Syndromes**
18 **Sexual Dysfunction**
1-3 p.m.—Ancora Psychiatric Hospital, Hammonton
(*Ancora Psychiatric Hospital and AMNJ*)
- 4 **Endocrinology—Dinner Meeting**
6:30-9:30 p.m.—Holiday Inn, East Orange
(*AMNJ Endocrinology Section*)
- 4 **Death and Dying**
11 7-9 p.m.—St. Joseph's Hospital and

- 18 Medical Center, Paterson
- 25 (*Passaic Valley Hospital Social Service Association and AMNJ*)
- 4 **Course for Psychiatrists—Semester I**
- 11 8-10 p.m.—Hackensack Hospital
- 18 (*NJ Psychoanalytic Society and AMNJ*)
- 25
- 4 **Advances in Medicine**
- 18 9:30-11 a.m.—Bergen Pines County
- 25 Hospital, Paramus
- (*Bergen Pines County Hospital and AMNJ*)
- 5 **Psychotherapeutic Techniques**
- 8-10 p.m.—312 Harding Drive, South
- Orange
- (*Group for Advanced Psychiatric Study and AMNJ*)
- 5 **Cardiology Conferences**
- 12 2:15-4:15 p.m.—Deborah Heart and
- 19 Lung Center, Browns Mills
- 26 (*Deborah Heart and Lung Center and AMNJ*)
- 5 **Psychiatric Lecture Series**
- 12 11 a.m.-12 noon—Greystone Park
- 19 Psychiatric Hospital
- 26 (*Greystone Park Psychiatric Hospital and AMNJ*)
- 5 **Grand Rounds and Case Presentations**
- 12 4-5 p.m.—Martland Hospital, Newark
- 19 (*CMDNJ and AMNJ*)
- 26
- 6 **Diagnostic and Therapeutic Problems in**
- 13 **Orthopedics**
- 27 7:30-9 a.m.—Alexian Brothers Hospital,
- Elizabeth
- (*Alexian Brothers Hospital*)
- 6 **Congestive Heart Failure**
- 8:30-9:30 a.m.—United Hospitals of
- Newark
- (*United Hospital of Newark and AMNJ*)
- 6 **Psychiatric Lecture Series**
- 13 1:30-5 p.m.—Trenton Psychiatric
- 20 Hospital
- 27 (*Trenton Psychiatric Hospital and AMNJ*)
- 7 **Symposium on Respiratory Care**
- 8:30 a.m.-1:00 p.m.—NJ Medical
- School, Newark
- (*NJ State Society of Anesthesiologists*)
- 7 **Seminar on Estrogens**
- 8:30 a.m.-1 p.m.—Clara Maass
- Memorial Hospital, Belleville
- (*Clara Maass Memorial Hospital and AMNJ*)
- 10 **Cardiac Arrhythmias**
- 17 **Congestive Heart Failure**
- 24 **Coronary Artery Disease**
- 11 a.m.-12 noon—Greystone Park
- Psychiatric Hospital
- (*Greystone Park Psychiatric Hospital and AMNJ*)
- 11 **Endocrine Conferences**
- 18 3:30-5 p.m.—Rotating between Newark
- 25 Beth Israel Medical Center, Martland,
- and East Orange VA Hospitals
- (*AMNJ*)
- 11 **Medical Aspects of Psychosomatic Illness**
- Part III
- 25 **Family Therapy—Part I**
- 3:15-4:15 p.m.—Fair Oaks Hospital,
- Summit
- (*Fair Oaks Hospital and AMNJ*)
- 11 **Alcoholism**
- 1:30-2:30 p.m.—John E. Runnells
- Hospital, Berkeley Heights
- (*John E. Runnells Hospital and AMNJ*)
- 12 **Care for the Spinal Cord Injured**
- 1-3 p.m.—VA Hospital, East Orange
- (*VA Hospital and AMNJ*)
- 12 **Women's Fear of Being Fat**
- 8:30-10:30 p.m.—Hackensack Hospital
- (*New Jersey Psychoanalytic Society and AMNJ*)
- 12 **Case Presentations and Guest Speakers**
- 7:30-9:30 p.m.—Location to be
- announced
- (*New Jersey Institute of Ultrasound in Medicine and AMNJ*)
- 17 **Current Chemotherapy**
- 7-8 p.m.—Irvington General Hospital
- (*Irvington General Hospital and AMNJ*)
- 17 **Laboratory Interpretations**
- 11:30 a.m.-12:30 p.m.—St. Mary's
- Hospital, Orange
- (*St. Mary's Hospital and AMNJ*)
- 17 **Medical Genetics**
- 2-3 p.m.—Ancora Psychiatric Hospital,
- Hammonton
- (*Ancora Psychiatric Hospital and AMNJ*)
- 18 **Emergency Medical Care**
- 1-2 p.m.—Trenton Psychiatric Hospital
- (*Trenton Psychiatric Hospital and AMNJ*)
- 18 **Heart Attack Prevention Through**
- Counseling**
- 9 a.m.-5 p.m.—Howard Johnson's,
- Newark
- (*CMDNJ and AMNJ*)
- 19 **Double Contrast Examination of the**
- Upper GI Tract**
- 7:15-10:15 p.m.—Hospital Center at
- Orange
- (*Diagnostic Radiology Section for Northern New Jersey and AMNJ*)
- 20 **Recent Advances in Perinatology**
- 8:15-10:30 a.m.—Overlook Hospital,
- Summit
- (*Overlook Hospital and AMNJ*)
- 21 **Advances in Medical Diagnosis Imaging**
- Hilton Inn, Eatontown
- (*Jersey Shore Medical Center and AMNJ*)
- 24 **Drug Interactions**
- 8-10 p.m.—The Englewood Club
- (*Englewood Surgical Society and AMNJ*)
- 25 **Neuropathology Conferences**
- 8-9:15 a.m.—New Jersey Medical
- School, Newark
- (*CMDNJ and AMNJ*)
- 25 **Cardiac Grand Rounds**
- 3-4:30 p.m.—CMDNJ-NJ Medical
- School, Newark
- (*American Heart Association, NJ Affiliate, and AMNJ*)
- 26 **Clinical Pathology Conference**
- 8-9 p.m.—John E. Runnells Hospital,
- Berkeley Heights
- (*John E. Runnells Hospital and AMNJ*)
- 26 **Advances in Antibiotics and Viral**
- Chemotherapy**
- 12 noon-1 p.m.—Carrier Foundation,
- Belle Mead
- (*The Carrier Foundation*)
- 31 **Effect of Changing Sex Roles in Marriage**
- 8-10 p.m.—Mayfair Farms Restaurant,
- West Orange
- (*TriCounty Chapter, NJ Psychiatric Association, and AMNJ*)
- Nov.
- 1 **Continuing Education in Psychiatry**
- 8 1-3 p.m.—Bergen Pines County Hospital
- 15 Paramus
- 22 (*Bergen Pines Hospital and AMNJ*)
- 1 **Emergency Care: Medical**
- 1-3 p.m.—Christ Hospital, Jersey City
- (*Christ Hospital and AMNJ*)
- 1 **Lectures in Obstetrics and Gynecology**
- 8-10 p.m.—Location varies
- (*CMDNJ and AMNJ*)
- 1 **Diagnosis of Anemic Patient**
- 29 **Clinical Immunology**
- 10:30 a.m.-12 noon—St. Mary's
- Hospital, Passaic
- (*St. Mary's Hospital and AMNJ*)
- 1 **Sexual Dysfunction-Case Histories**
- 15 **Sexual Dysfunction-Research**
- 29 **Psychiatric Emergencies**
- 1-3 p.m.—Ancora Psychiatric Hospital
- (*Ancora Psychiatric Hospital and AMNJ*)
- 1 **Hypertension**
- 8 **CEA Program**
- 15 **Chemotherapy of Breast Tumors**
- 22 **Chartmanship**
- 29 **Radiology-Pathology Conference**
- 11:30 a.m.-1:30 p.m.—Rahway Hospital
- (*Rahway Hospital and AAFP*)
- 1 **Grand Rounds and Case Presentations**
- 8 2-4 p.m.—Rotating between Martland,
- 15 Newark Beth Israel, St. Michaels, St.
- 22 Joseph's Hospitals and Jersey City
- 29 Medical Center
- (*CMDNJ and AMNJ*)
- 1 **Clinical Pathology Grand Rounds**
- 8 12 noon-1 p.m.—New Jersey Medical
- 15 School, Newark
- 22 (*CMDNJ and AMNJ*)
- 29
- 1 **Spectrum of Arthritis**
- 8 **Selection of Therapy for Aortic Valve**
- Disease**
- 15 **Anerobic Infections**
- 22 **Some Areas of Controversy in Cardiology**
- 29 **Drug-Induced Psychoses**
- 9-11 a.m.—Middlesex General Hospital,
- New Brunswick
- (*Middlesex General Hospital, AMNJ and AAFP*)
- 1 **Medical Grand Rounds**
- 11:30 a.m.—Rotates between Newark
- Beth Israel Medical Center, Martland,
- and East Orange VA Hospitals
- (*AMNJ*)
- 1 **Hypertension Update**
- 1:45-5:45 p.m.—Rutgers Medical
- School, Piscataway
- (*CMDNJ and AMNJ*)
- 1 **Endocrinology—Dinner Meeting**
- 6:30-9:30 p.m.—Holiday Inn, East
- Orange
- (*AMNJ Endocrinology Section*)
- 1 **Advances in Medicine**
- 8 9:30-11 a.m.—Bergen Pines County
- 15 Hospital
- 22 (*Bergen Pines County Hospital and AMNJ*)
- 29
- 1 **Course for Psychiatrists—Semester I**
- 8 8-10 p.m.—Hackensack Hospital
- 15 (*NJ Psychoanalytic Society and AMNJ*)
- 2 **Psychotherapeutic Techniques**
- 8-10 p.m.—312 Harding Drive, South
- Orange
- (*Group for Advanced Psychiatric Study and AMNJ*)
- 2 **Cardiology Conferences**
- 9 2:15-4:15 p.m.—Deborah Heart and
- 16 Lung Center, Browns Mills
- 30 (*Deborah Heart and Lung Center and AMNJ*)

- 2 **Education in Human Sexuality**
- 9 **Conceptual Problems in Diagnosis**
12 noon-1 p.m.—Carrier Foundation,
Belle Mead
(*The Carrier Foundation*)
- 2 **Psychiatric Lecture Series**
- 9 11 a.m.-12 noon—Greystone Park
16 **Psychiatric Hospital**
30 (*Greystone Park Psychiatric Hospital and
AMNJ*)
- 2 **Grand Rounds and Case Presentations**
- 9 4-5 p.m.—Martland Hospital, Newark
16 (*CMDNJ and AMNJ*)
- 30
- 3 **Diagnostic and Therapeutic Problems in**
- 10 **Orthopedics**
- 24 7:30-9 a.m.—Alexian Brothers Hospital,
Elizabeth
(*Alexian Brothers Hospital*)
- 3 **Colitis**
8:30-9:30 a.m.—United Hospitals of
Newark
(*United Hospitals of Newark and AMNJ*)
- 3 **Psychiatric Lecture Series**
- 10 1:30-5 p.m.—Trenton Psychiatric
17 **Hospital**
(*Trenton Psychiatric Hospital and
AMNJ*)
- 6 **Psychiatric Lecture Series**
8-10 p.m.—4 Garden Place, Nutley
(*Essex Psychiatric Seminar and AMNJ*)
- 6 **Neuroscience Conference**
- 13 11:30 a.m.-12:30 p.m.—Bergen Pines
20 **County Hospital, Paramus**
27 (*Bergen Pines County Hospital and
AMNJ*)
- 7 **Seminar on Law and Psychiatry**
- 14 3:30-5:30 p.m.—Rutgers Law School,
21 **Newark**
(*Rutgers University Law School and
AMNJ*)
- 7 **Lecture Series in Otolaryngology**
8-9 p.m.—Garden State Community
Hospital, Marlton
(*Garden State Community Hospital and
AMNJ*)
- 7 **An In-Depth View of the Vagus**
5-6 p.m.—Rutgers Medical School,
Piscataway
(*CMDNJ and AMNJ*)
- 8 **Family Therapy—Part II**
- 22 **Family Therapy—Part III**
3:15-4:15 p.m.—Fair Oaks Hospital,
Summit
(*Fair Oaks Hospital and AMNJ*)
- 8 **Drug Addiction**
1:30-2:30 p.m.—John E. Runnells
Hospital, Berkeley Heights
(*John E. Runnells Hospital and AMNJ*)
- 8 **Endocrine Conferences**
- 15 3:30-5 p.m.—Rotates between Newark
22 **Beth Israel Medical Center, Martland,**
29 **and East Orange VA Hospitals**
(*AMNJ*)
- 8 **Learning Disorders 1-5 p.m.**
Children of Divorce 8-9 p.m.—Ramada
Inn, Clark
(*NJ Chapter, AAP and AMNJ*)
- 9 **Outpatient Treatment of Burns**
8-9 p.m.—Zurbrugg Memorial Hospital,
Riverside
*Burlington County Medical Society and
AMNJ*)
- 9 **Case Presentations and Guest Speakers**
7:30-9:30 p.m.—Location to be
announced
- (*New Jersey Institute of Ultrasound in
Medicine and AMNJ*)
- 11 **Regional Meeting 9 a.m.**
- 12 **Office Gynecology 9 a.m.-4 p.m.**—
Cherry Hill Hyatt House
(*AMA Council on Continuing Physician
Education and AMNJ*)
- 14 **Malpractice**
2-3 p.m.—Ancora Psychiatric Hospital,
Hammonton
(*Ancora Psychiatric Hospital and AMNJ*)
- 14 **Adrenal Diseases**
- 21 **Diabetes**
- 28 **Obesity**
11 a.m.-12 noon—Greystone Park
Psychiatric Hospital
(*Greystone Park Psychiatric Hospital and
AMNJ*)
- 15 **Diagnosis and Management of GIT**
Bleeding
1-2 p.m.—Trenton Psychiatric Hospital
(*Trenton Psychiatric Hospital and
AMNJ*)
- 15 **Recent Advances in Gastroenterology**
9 a.m.-5 p.m.—VA Hospital, East
Orange
(*VA Hospital and AMNJ*)
- 15 **Fall Refresher Seminar**
8:30 a.m.-4:45 p.m.—John F. Kennedy
Medical Center, Edison
(*New Jersey Chapter, AAFP, and AMNJ*)
- 16 **Annual George Gross Memorial Lecture:**
Leukemia Treatment Today
9:30 a.m.-12:30 p.m.—Newark Beth
Israel Medical Center
(*Newark Beth Israel Medical Center and
AMNJ*)
- 16 **CAT Scanning**
7:15-10:15 p.m.—Hospital Center at
Orange
(*Diagnostic Radiology Section for
Northern New Jersey and AMNJ*)
- 17 **Recent Advances in Genetic Diagnosis and**
Counseling
8:15-10:30 a.m.—Overlook Hospital,
Summit
(*Overlook Hospital and AMNJ*)
- 21 **Gastrointestinal Bleeding**
7-8 p.m.—Irvington General Hospital
(*Irvington General Hospital and AMNJ*)
- 21 **Current Chemotherapy**
11:30 a.m.-12:30 p.m.—St. Mary's
Hospital, Orange
(*St. Mary's Hospital and AMNJ*)
- 22 **Neuropathology Conferences**
8-9:15 a.m.—New Jersey Medical
School, Newark
(*CMDNJ and AMNJ*)
- 28 **Malignant Hyperthermia**
8-10 p.m.—The Englewood Club,
Englewood
(*Englewood Surgical Society and AMNJ*)
- 29 **Cardiac Grand Rounds**
3-4:30 p.m.—NJ Medical School,
Newark
(*American Heart Association, NJ
Affiliate and AMNJ*)
- Dec.
- 1 **Proper Use of Antibiotics**
8:30-9:30 a.m.—United Hospitals of
Newark
(*United Hospitals of Newark and AMNJ*)
- 1 **Diagnostic and Therapeutic Problems in**
- 8 **Orthopedics**
- 22 7:30-9 a.m.—Alexian Brothers Hospital,
Elizabeth
(*Alexian Brothers Hospital*)
- 1 **Psychiatric Lecture Series**
1:30-5 p.m.—Trenton Psychiatric
Hospital
(*Trenton Psychiatric Hospital and
AMNJ*)
- 4 **Neuroscience Conferences**
- 11 11:30 a.m.-12:30 p.m.—Bergen Pines
- 18 **County Hospital, Paramus**
(*Bergen Pines County Hospital and
AMNJ*)
- 4 **Psychiatric Lecture Series**
8-10 p.m.—192 Chittenden Rd., Clifton
(*Essex Psychiatric Seminar and AMNJ*)
- 5 **Gastrointestinal Bleeding**
8-9 p.m.—Burdette Tomlin Memorial
Hospital, Cape May Courthouse
(*Burdette Tomlin Memorial Hospital and
AMNJ*)
- 5 **Colorectal Carcinoma**
5-6 p.m.—Rutgers Medical School,
Piscataway
(*CMDNJ and AMNJ*)
- 5 **Medical Emergency Care**
- 12 **Colitis**
- 19 **Medical Genetics**
11 a.m.-12 noon—Greystone Park
Psychiatric Hospital
(*Greystone Park Psychiatric Hospital and
AMNJ*)
- 5 **Seminar on Law and Psychiatry**
- 12 3:30-5:30 p.m.—Rutgers Law School,
19 **Newark**
26 (*Rutgers University Law School and
AMNJ*)
- 6 **Endocrinology—Dinner Meeting**
6:30-9:30 p.m.—Holiday Inn, East
Orange
(*AMNJ Endocrinology Section*)
- 6 **Advances in Medicine**
- 13 9:30-11 a.m.—Bergen Pines County
- 20 **Hospital, Paramus**
27 (*Bergen Pines County Hospital and
AMNJ*)
- 6 **Continuing Education in Psychiatry**
- 13 1-3 p.m.—Bergen Pines County
- 20 **Hospital, Paramus**
27 **Paramus**
(*Bergen Pines Hospital and AMNJ*)
- 6 **Genetics**
1-3 p.m.—Christ Hospital, Jersey City
(*Christ Hospital and AMNJ*)
- 6 **Lectures in Obstetrics and Gynecology**
8-10 p.m.—Location Varies
(*CMDNJ and AMNJ*)
- 6 **Sepsis and Endotoxic Shock**
10:30 a.m.-12 noon—St. Mary's
Hospital, Passaic
(*St. Mary's Hospital and AMNJ*)
- 6 **Psychiatric Emergencies**
- 20 **Antianxiety and Antidepressants**
1-3 p.m.—Ancora Psychiatric Hospital,
Hammonton
(*Ancora Psychiatric Hospital and AMNJ*)
- 6 **Systemic Mycoses**
- 13 **Nutritional Issues in Clinical Medicine**
- 20 **Endocrine Aspects of Aging**
9-11 a.m.—Middlesex General Hospital,
New Brunswick
(*Middlesex General Hospital, AMNJ and
AAFP*)
- 6 **Medical Grand Rounds**
11:30 a.m.—Rotates between Newark
Beth Israel Medical Center, Martland,

- and East Orange VA Hospitals
(*AMNJ Endocrinology Section*)
- 6 **The Anxiety Syndrome**
- 13 **Antibiotic Rx**
- 20 **Common Hematologic Problems**
11:30 a.m.-1:30 p.m.—Rahway Hospital
(*Rahway Hospital and AAFP*)
- 6 **Grand Rounds and Case Presentations**
- 13 2-4 p.m.—Rotates between Martland,
20 Newark Beth Israel, St. Michael's, St.
27 Joseph's Hospitals and Jersey City
Medical Center
(*CMDNJ and AMNJ*)
- 6 **Clinical Pathology Grand Rounds**
- 13 12 noon-1 p.m.—New Jersey Medical
20 School, Newark
27 (*CMDNJ and AMNJ*)
- 7 **Psychiatric Lecture Series**
- 14 11 a.m.-12 noon—Greystone Psychiatric
21 Hospital
(*Greystone Psychiatric Hospital and
AMNJ*)
- 7 **Grand Rounds and Case Presentations**
- 14 4-5 p.m.—Martland Hospital, Newark
21 (*CMDNJ and AMNJ*)
- 28
- 7 **Psychiatric Ethics**
- 14 **Hysterical Dissociation**
12 noon-1 p.m.—Carrier Foundation,
Belle Mead
(*The Carrier Foundation*)
- 7 **Psychotherapeutic Techniques**
8-10 p.m.—312 Harding Drive, South
Orange
(*Group for Advanced Psychiatric Study
and AMNJ*)
- 7 **Cardiology Conferences**
- 14 2:15-4:15 p.m.—Deborah Heart and
21 Lung Center, Browns Mills
28 (*Deborah Heart and Lung Center and
AMNJ*)
- 12 **Clinical Pharmacology**
12-3 p.m.—Ancora Psychiatric Hospital,
Hammonton
(*Ancora Psychiatric Hospital and AMNJ*)
- 12 **Pulmonary Disease-Proper Use of Blood
Gases**
8:30-9:30 p.m.—Omar's Restaurant,
Saddle River Road, Fair Lawn
(*Fair Lawn Memorial Hospital and
AMNJ*)
- 13 **Endocrine Conferences**
- 20 3:30-5 p.m.—Rotates between Newark
27 Beth Israel Medical Center, Martland,
and East Orange VA Hospitals
(*AMNJ*)
- 14 **Case Presentations and Guest Speakers**
7:30-9:30 p.m.—Location to be
announced
(*New Jersey Institute of Ultrasound in
Medicine and AMNJ*)
- 15 **Management of the Juvenile Diabetic**
8:15-10:30 a.m.—Overlook Hospital,
Summit
(*Overlook Hospital and AMNJ*)
- 19 **Cardiopulmonary Complications of the
Surgical Patient**
8-10 p.m.—The Englewood Club,
Englewood
(*Englewood Surgical Society and AMNJ*)
- 19 **Adrenal Diseases**
11:30 a.m.-12:30 p.m.—St. Mary's
Hospital, Orange
(*St. Mary's Hospital and AMNJ*)
- 20 **Diagnosis and Management of Shock**
1-2 p.m.—Trenton Psychiatric Hospital
(*Trenton Psychiatric Hospital and
AMNJ*)
- 27 **Neuropathology Conferences**
8-9:15 a.m.—New Jersey Medical
School, Newark
(*CMDNJ and AMNJ*)
- 27 **Cardiac Grand Rounds**
3-4:30 p.m.—NJ Medical School,
Newark
(*American Heart Association, NJ
Affiliate and AMNJ*)
- Jan.
- 2 **Seminar on Law and Psychiatry**
- 9 3:30-5:30 p.m.—Rutgers Law School,
16 Newark
23 (*Rutgers University Law School and
AMNJ*)
- 30
- 3 **Lectures in Obstetrics and Gynecology**
8-10 p.m.—Location Varies
(*CMDNJ and AMNJ*)
- 3 **Endocrinology—Dinner Meeting**
6:30-9:30 p.m.—Holiday Inn, East
Orange
(*AMNJ Endocrinology Section*)
- 3 **Medical Grand Rounds**
11:30 a.m.—Rotates between Newark
Beth Israel Medical Center, Martland,
and East Orange VA Hospitals
(*AMNJ*)
- 3 **Seizure Disorders, Diagnosis and
Management**
- 31 **Congenital Diseases**
10:30 a.m.-12 noon—St. Mary's
Hospital, Passaic
(*St. Mary's Hospital and AMNJ*)
- 3 **Psychopharmacology Update**
- 17 **Epilepsy and Convulsive Disorders**
- 31 **Psychosomatic Medicine**
1-3 p.m.—Ancora Psychiatric Hospital,
Hammonton
(*Ancora Psychiatric Hospital and AMNJ*)
- 3 **Immunology: Clinical**
- 10 Topic to be announced
- 17 **Difficult Biliary Problems**
- 24 Topic to be announced
- 31 **Sports Medicine**
1-3 p.m.—Christ Hospital, Jersey City
(*Christ Hospital and AMNJ*)
- 3 **Drugs and Pregnancy**
- 10 **Adolescent Health Care**
- 17 **The Addictive Personality: Drug and
Alcohol Dependence**
- 24 **Drug Therapy in Psychiatric Disorders of
Older Patients**
- 31 **Management of Acute and Chronic
Alcoholism in Clinical Patients**
9-11 a.m.—Middlesex General Hospital,
New Brunswick
(*Middlesex General Hospital, AMNJ and
AAFP*)
- 3 **Grand Rounds and Case Presentations**
- 10 2-4 p.m.—Rotating between Martland,
17 Newark Beth Israel, St. Michael's, St.
24 Joseph's Hospitals, and Jersey City
31 Medical Center
(*CMDNJ and AMNJ*)
- 3 **Clinical Pathology Grand Rounds**
- 10 12 noon-1 p.m.—NJ Medical School,
17 Newark
24 (*CMDNJ and AMNJ*)
- 31
- 3 **Advances in Medicine**
- 10 9:30-11 a.m.—Bergen Pines County
17 Hospital, Paramus
24 (*Bergen Pines County Hospital and
AMNJ*)
- 31
- 3 **Endocrine Conference**
- 10 3:30-5 p.m.—Rotates between Newark
17 Beth Israel Medical Center, Martland,
24 and East Orange VA Hospitals
31 (*AMNJ Endocrinology Section*)
- 4 **Psychotherapeutic Techniques**
8-10 p.m.—312 Harding Drive, South
Orange
(*Group for Advanced Psychiatric Study
and AMNJ*)
- 4 **Psychiatric Lecture Series**
- 11 11 a.m.-12 noon—Greystone Park
18 Psychiatric Hospital
25 (*Greystone Park Psychiatric Hospital and
AMNJ*)
- 4 **Grand Rounds and Case Presentations**
- 11 4-5 p.m.—Martland Hospital, Newark
18 (*CMDNJ and AMNJ*)
- 25
- 4 **Cardiology Conferences**
- 11 2:15-4:15 p.m.—Deborah Heart and
18 Lung Center, Browns Mills
25 (*Deborah Heart and Lung Center and
AMNJ*)
- 5 **Obesity**
8:30-9:30 a.m.—United Hospitals of
Newark
(*United Hospitals of Newark and AMNJ*)
- 5 **Diagnostic and Therapeutic Problems in
Orthopedics**
- 12
- 26 7:30-9 a.m.—Alexian Brothers Hospital,
Elizabeth
(*Alexian Brothers Hospital*)
- 8 **Psychiatric Lecture Series**
8-10 p.m.—111 Ridgewood Ave., Glen
Ridge
(*Essex Psychiatric Seminar and AMNJ*)
- 8 **Neuroscience Conferences**
- 15 11:30 a.m.-12:30 p.m.—Bergen Pines
22 County Hospital, Paramus
29 (*Bergen Pines County Hospital and
AMNJ*)
- 9 **Bleeding Diseases**
- 16 **Diagnosis of Anemic Patient**
- 23 **Management of Hepatitis**
11 a.m.-12 noon—Greystone Park
Psychiatric Hospital
(*Greystone Park Psychiatric Hospital and
AMNJ*)
- 10 **Alcoholism**
11:30 a.m.-12:30 p.m.—Rahway
Hospital
(*Rahway Hospital and AMNJ*)
- 10 **Cerebral Vascular Disease**
1:30-2:30 p.m.—John E. Runnells
Hospital, Berkeley Heights
(*John E. Runnells Hospital and AMNJ*)
- 11 **Psychogeography**
8:30-10:30 p.m.—Hackensack Hospital
(*Hackensack Hospital and AMNJ*)
- 11 **Case Presentations with Guest Speakers**
7:30-9:30 p.m.—Location to be
announced
(*NJ Institute of Ultrasound in Medicine
and AMNJ*)
- 16 **Hepatitis**
7-8 p.m.—Irvington General Hospital
(*Irvington General Hospital and AMNJ*)
- 16 **Seizure Disorders**
11:30 a.m.-12:30 p.m.—St. Mary's
Hospital, Orange
(*St. Mary's Hospital and AMNJ*)
- 17 **Thanatology**
1-2 p.m.—Trenton Psychiatric Hospital
(*Trenton Psychiatric Hospital and
AMNJ*)

- 18 **Aneurysms of the Aorta**
7:15-10:15 p.m.—Hospital Center at Orange
(*Diagnostic Radiology Section for Northern New Jersey and AMNJ*)
- 23 **Alcoholism**
8-9 p.m.—Warren Hospital, Phillipsburg
(*Warren Hospital and AMNJ*)
- 23 **Fundamentals of Hemostasis for Surgeons**
8-10 p.m.—The Englewood Club, Englewood
(*Englewood Surgical Society and AMNJ*)
- 24 **Neuropathology Conferences**
8-9:15 a.m.—NJ Medical School, Newark
(*CMDNJ and AMNJ*)
- 31 **Cardiac Grand Rounds**
3-4:30 p.m.—NJ Medical School, Newark
(*American Heart Association, NJ Affiliate and AMNJ*)
- Feb.
- 1 **Psychotherapeutic Techniques**
8-10 p.m.—312 Harding Drive, South Orange
(*Group for Advanced Psychiatric Study and AMNJ*)
- 1 **Psychiatric Lecture Series**
8 11 a.m.-12 noon—Greystone Park
15 Psychiatric Hospital
22 (*Greystone Park Psychiatric Hospital and AMNJ*)
- 1 **Grand Rounds and Case Presentations**
8 4-5 p.m.—Martland Hospital, Newark
15 (*CMDNJ and AMNJ*)
- 22 **Cardiology Conferences**
8 2:15-4:15 p.m.—Deborah Heart and
15 Lung Center, Browns Mills
22 (*Deborah Heart and Lung Center and AMNJ*)
- 2 **Head and Neck Cancer**
8:30-9:30 a.m.—United Hospitals of Newark
(*United Hospitals of Newark and AMNJ*)
- 2 **Diagnostic and Therapeutic Problems in**
9 **Orthopedics**
23 7:30-9 a.m.—Alexian Brothers Hospital, Elizabeth
(*Alexian Brothers Hospital*)
- 5 **Intermittent Treatment of a Schizophrenic**
8-10 p.m.—39 Crescent Ave., Passaic
(*Essex Psychiatric Seminar and AMNJ*)
- 5 **Neuroscience Conferences**
12 11:30 a.m.-12:30 p.m.—Bergen Pines
19 County Hospital, Paramus
26 (*Bergen Pines County Hospital and AMNJ*)
- 6 **Seminar on Law and Psychiatry**
13 3:30-5:30 p.m.—Rutgers Law School,
20 Newark
27 (*Rutgers University Law School and AMNJ*)
- 7 **Lectures in Obstetrics and Gynecology**
8-10 p.m.—Location varies
(*CMDNJ and AMNJ*)
- 7 **Endocrinology—Dinner Meeting**
6:30-9:30 p.m.—Holiday Inn, East Orange
(*AMNJ Endocrinology Section*)
- 7 **Medical Grand Rounds**
11:30 a.m.—Rotates between Newark Beth Israel Medical Center, Martland, and East Orange VA Hospitals
(*AMNJ*)
- 7 **Infertility, Diagnosis and Management**
10:30 a.m.-12 noon—St. Mary's Hospital, Passaic
(*St. Mary's Hospital and AMNJ*)
- 7 **Obesity**
11:30 a.m.-12:30 p.m.—Rahway Hospital
(*Rahway Hospital and AMNJ*)
- 7 **Psychosomatic Medicine**
- 14 **Hospital Psychiatry—Principles**
- 21 **Hospital Psychiatry—Rx**
1-3 p.m.—Ancora Psychiatric Hospital, Hammonton
(*Ancora Psychiatric Hospital and AMNJ*)
- 7 **Nephrology: Fluid and Electrolyte Imbalance**
- 14 To be announced
- 21 To be announced
- 28 To be announced
1-3 p.m.—Christ Hospital, Jersey City
(*Christ Hospital and AMNJ*)
- 7 **Urinary Tract Infections**
- 14 **Blood Pressure and the Kidney**
- 21 **Diuresis and Antidiuresis**
- 28 **Digestive Disease**
9-11 a.m.—Middlesex General Hospital, New Brunswick
(*Middlesex General Hospital, AMNJ and AAFP*)
- 7 **Grand Rounds and Case Presentations**
- 14 2-4 p.m.—Rotating between Martland,
21 Newark Beth Israel, St. Michael's, St.
28 Joseph's Hospitals and Jersey City Medical Center
(*CMDNJ and AMNJ*)
- 7 **Clinical Pathology Grand Rounds**
- 14 12 noon-1 p.m.—NJ Medical School,
21 Newark
28 (*CMDNJ and AMNJ*)
- 7 **Advances in Medicine**
- 14 9:30 a.m.-11 a.m.—Bergen Pines County
21 Hospital, Paramus
28 (*Bergen Pines County Hospital and AMNJ*)
- 7 **Endocrine Conferences**
- 14 3:30-5 p.m.—Rotates between Newark
21 Beth Israel Medical Center, Martland, and East Orange VA Hospitals
(*AMNJ*)
- 8 **The Voice of Conscience**
8:30-10:30 p.m.—Location to be announced
(*NJ Psychoanalytic Society and AMNJ*)
- 8 **Case Presentations and Guest Speakers**
7:30-9:30 p.m.—Location to be announced
(*NJ Institute of Ultrasound in Medicine and AMNJ*)
- 13 **Clinical Immunology**
- 20 **Sepsis Shock**
- 27 **Laboratory Interpretations**
11 a.m.-12 noon—Greystone Park Psychiatric Hospital
(*Greystone Park Psychiatric Hospital and AMNJ*)
- 14 **Blood Gases**
1:30-2:30 p.m.—John E. Runnells Hospital, Berkeley Heights
(*John E. Runnells Hospital and AMNJ*)
- 20 **Infectious Diseases—Endotoxic Shock**
7-8 p.m.—Irvington General Hospital
(*Irvington General Hospital and AMNJ*)
- 20 **Breast Cancer**
11:30 a.m.-12:30 p.m.—St. Mary's Hospital, Orange
(*St. Mary's Hospital and AMNJ*)
- 21 **Addicts**
1-2 p.m.—Trenton Psychiatric Hospital
(*Trenton Psychiatric Hospital and AMNJ*)
- 27 **Malpractice**
8-9 p.m.—Warren Hospital, Phillipsburg
(*Warren Hospital and AMNJ*)
- 27 **Ultrasound Diagnosis**
8-10 p.m.—The Englewood Club, Englewood
(*Englewood Surgical Society and AMNJ*)
- 28 **Neuropathology Conferences**
8-9:15 a.m.—NJ Medical School, Newark
(*CMDNJ and AMNJ*)
- 28 **Cardiac Grand Rounds**
3-4:30 p.m.—NJ Medical School, Newark
(*American Heart Association, NJ Affiliate and AMNJ*)
- Mar.
- 1 **Psychotherapeutic Techniques**
8-10 p.m.—312 Harding Drive, South Orange
(*Group for Advanced Psychiatric Study and AMNJ*)
- 1 **Psychiatric Lecture Series**
8 11 a.m.-12 noon—Greystone Park
15 Psychiatric Hospital
22 (*Greystone Park Psychiatric Hospital and AMNJ*)
- 1 **Grand Rounds and Case Presentations**
8 4-5 p.m.—Martland Hospital, Newark
15 (*CMDNJ and AMNJ*)
- 22 **Cardiology Conferences**
8 2:15-4:15 p.m.—Deborah Heart and
15 Lung Center, Browns Mills
22 (*Deborah Heart and Lung Center and AMNJ*)
- 2 **Pharmacology, Clinical**
8:30-9:30 a.m.—United Hospitals of Newark
(*United Hospitals of Newark and AMNJ*)
- 2 **Diagnostic and Therapeutic Problems in**
9 **Orthopedics**
23 7:30-9 a.m.—Alexian Brothers Hospital, Elizabeth
(*Alexian Brothers Hospital*)
- 5 **An Adolescent Girl in a Lolie à deux**
8-10 p.m.—111 Ridgewood Ave., Glen Ridge
(*Essex Psychiatric Seminar and AMNJ*)
- 5 **Neuroscience Conferences**
12 11:30 a.m.-12:30 p.m.—Bergen Pines
19 County Hospital, Paramus
26 (*Bergen Pines County Hospital and AMNJ*)
- 6 **Seminar on Law and Psychiatry**
13 3:30-5:30 p.m.—Rutgers Law School,
20 Newark
27 (*Rutgers University Law School and AMNJ*)
- 7 **Lectures in Obstetrics and Gynecology**
8-10 p.m.—Location varies
(*CMDNJ and AMNJ*)
- 7 **Endocrinology—Dinner Meeting**
6:30-9:30 p.m.—Holiday Inn, East Orange
(*AMNJ Endocrinology Section*)
- 7 **Medical Grand Rounds**
11:30 a.m.—Rotates between Newark Beth Israel Medical Center, Martland,

- and East Orange VA Hospitals
(*AMNJ*)
- 7 **Clinical Pharmacology**
10:30 a.m.-12 noon—St. Mary's
Hospital, Passaic
(*St. Mary's Hospital and AMNJ*)
- 7 **Malpractice**
11:30 a.m.-12:30 p.m.—Rahway
Hospital
(*Rahway Hospital and AMNJ*)
- 7 **Forensic Psychiatry—Concepts and Areas
of Concern**
- 14 **Forensic Psychiatry—Recent Trends**
- 21 **Phobic and OBS, Compulsive Neurosis**
1-3 p.m.—Ancora Psychiatric Hospital,
Hammonton
(*Ancora Psychiatric Hospital and AMNJ*)
- 7 **Orthopedic Problems: Bone Tumors**
- 14 To be announced
- 21 To be announced
- 28 To be announced
1-3 p.m.—Christ Hospital, Jersey City
(*Christ Hospital and AMNJ*)
- 7 **Vasodilator Therapy in Heart Disease**
- 14 **Current Problems in Transplantation**
- 21 **Gastrointestinal Disorders Among
Children**
- 28 **Psychopathology of Sexual Dysfunction**
9-11 a.m.—Middlesex General Hospital,
New Brunswick
(*Middlesex General Hospital, AMNJ and
AAFP*)
- 7 **Grand Rounds and Case Presentations**
- 14 2-4 p.m.—Rotating between Martland,
21 Newark Beth Israel, St. Michael's, St.
28 Joseph's Hospitals and Jersey City
Medical Center
(*CMDNJ and AMNJ*)
- 7 **Clinical Pathology Grand Rounds**
- 14 12 noon-1 p.m.—NJ Medical School,
21 Newark
28 (*CMDNJ and AMNJ*)
- 7 **Advances in Medicine**
- 14 9:30 a.m.-11 a.m.—Bergen Pines County
21 Hospital, Paramus
28 (*Bergen Pines County Hospital and
AMNJ*)
- 7 **Endocrine Conferences**
- 14 3:30-5 p.m.—Rotates between Newark
21 Beth Israel Medical Center, Martland,
28 and East Orange VA Hospitals
(*AMNJ*)
- 8 **Case Presentations and Guest Speakers**
7:30-9:30 p.m.—Location to be
announced
(*NJ Institute of Ultrasound in Medicine
and AMNJ*)
- 13 **Acute Renal Failure**
- 20 **Chronic Renal Failure**
- 27 **Fluid and Electrolyte Imbalance**
11 a.m.-12 noon—Greystone Park
Psychiatric Hospital
(*Greystone Park Psychiatric Hospital and
AMNJ*)
- 15 **Combined Radiology and Orthopedic
Meeting**
7:15-10:15 p.m.—Hospital Center at
Orange
(*Diagnostic Radiology Section for
Northern NJ and AMNJ*)
- 20 **Surgical Management—Ulcerative Colitis**
7-8 p.m.—Irvington General Hospital
(*Irvington General Hospital and AMNJ*)
- 20 **Nuclear Medicine**
11:30 a.m.-12:30 p.m.—St. Mary's
Hospital, Orange
(*St. Mary's Hospital and AMNJ*)
- 27 **Head and Neck Cancer**
8-9 p.m.—Warren Hospital, Phillipsburg
(*Warren Hospital and AMNJ*)
- 28 **Neuropathology Conferences**
8-9:15 a.m.—NJ Medical School,
Newark
(*CMDNJ and AMNJ*)
- 28 **Cardiac Grand Rounds**
3-4:30 p.m.—NJ Medical School,
Newark
(*American Heart Association, NJ
Affiliate and AMNJ*)
- Apr.
- 2 **Voyeurism and Sexual Deviation in a
Young Man**
8-10 p.m.—60 Melrose Place, Montclair
(*Essex Psychiatric Seminar and AMNJ*)
- 2 **Neuroscience Conferences**
- 9 11:30 a.m.-12:30 p.m.—Bergen Pines
16 County Hospital, Paramus
23 (*Bergen Pines County Hospital and
AMNJ*)
- 30 **Seminar on Law and Psychiatry**
- 3 3:30-5:30 p.m.—Rutgers Law School,
10 Newark
17 (*Rutgers University Law School and
AMNJ*)
- 24 **Lectures in Obstetrics and Gynecology**
8-10 p.m.—Location varies
(*CMDNJ and AMNJ*)
- 4 **Endocrinology—Dinner Meeting**
6:30-9:30 p.m.—Holiday Inn, East
Orange
(*AMNJ Endocrinology Section*)
- 4 **Medical Grand Rounds**
11:30 a.m.—Rotates between Newark
Beth Israel Medical Center, Martland,
and East Orange VA Hospitals
(*AMNJ Endocrinology Section*)
- 4 **Lung Disorders and Blood Gases**
10:30 a.m.-12 noon—St. Mary's
Hospital, Passaic
(*St. Mary's Hospital and AMNJ*)
- 4 **Clinical Pharmacology**
11:30 a.m.-12:30 p.m.—Rahway
Hospital
(*Rahway Hospital and AMNJ*)
- 4 **Violence-Evaluation/Concepts**
- 18 **Psychological Testing**
1-3 p.m.—Ancora Psychiatric Hospital,
Hammonton
(*Ancora Psychiatric Hospital and AMNJ*)
- 4 **Medical Lecture Series**
- 18 1-3 p.m.—Christ Hospital, Jersey City
25 (*Christ Hospital and AMNJ*)
- 4 **Nonmalignant Disorders of the Bowel**
- 11 **Fever of Obscure Origin**
- 18 **Contact Dermatitis—1979**
- 25 **Colorectal Polyps and Cancers**
9-11 a.m.—Middlesex General Hospital,
New Brunswick
(*Middlesex General Hospital, AMNJ and
AAFP*)
- 4 **Grand Rounds and Case Presentations**
- 11 2-4 p.m.—Rotating between Martland,
18 Newark Beth Israel, St. Michael's, St.
25 Joseph's Hospitals and Jersey City
Medical Center
(*CMDNJ and AMNJ*)
- 4 **Clinical Pathology Grand Rounds**
- 11 12 noon-1 p.m.—NJ Medical School,
18 Newark
25 (*CMDNJ and AMNJ*)
- 4 **Advances in Medicine**
- 11 9:30-11 a.m.—Bergen Pines County
Hospital, Paramus
25 (*Bergen Pines County Hospital and
AMNJ*)
- 18 **Endocrine Conferences**
- 11 3:30-5 p.m.—Rotates between Newark
18 Beth Israel Medical Center, Martland,
25 and East Orange VA Hospitals
(*AMNJ*)
- 5 **Psychotherapeutic Techniques**
8-10 p.m.—312 Harding Drive, South
Orange
(*Group for Advanced Psychiatric Study
and AMNJ*)
- 5 **Psychiatric Lecture Series**
- 12 11 a.m.-12 noon—Greystone Park
19 Psychiatric Hospital
26 (*Greystone Park Psychiatric Hospital and
AMNJ*)
- 5 **Grand Rounds and Case Presentations**
- 12 4-5 p.m.—Martland Hospital, Newark
19 (*CMDNJ and AMNJ*)
- 26 **Cardiology Conferences**
- 12 2:15-4:15 p.m.—Deborah Heart and
19 Lung Center, Browns Mills
26 (*Deborah Heart and Lung Center and
AMNJ*)
- 6 **Arthritis**
8:30-9:30 a.m.—United Hospitals of
Newark
(*United Hospitals of Newark and AMNJ*)
- 6 **Diagnostic and Therapeutic Problems in
Orthopedics**
- 13 7:30-9 a.m.—Alexian Brothers Hospital,
27 Elizabeth
(*Alexian Brothers Hospital*)
- 10 **Cerebral Vascular Disease**
- 17 **Headache**
- 24 **Seizure Disorders**
11 a.m.-12 noon—Greystone Park
Psychiatric Hospital
(*Greystone Park Psychiatric Hospital and
AMNJ*)
- 11 **Depression and Anxiety**
1:30-2:30 p.m.—John E. Runnells
Hospital, Berkeley Heights
(*John E. Runnells Hospital and AMNJ*)
- 12 **Case Presentations and Guest Speakers**
7:30-9:30 p.m.—Location to be
announced
(*NJ Institute of Ultrasound in Medicine
and AMNJ*)
- 17 **Colon and Rectal Cancer**
11:30 a.m.-12:30 p.m.—St. Mary's
Hospital, Orange
(*St. Mary's Hospital and AMNJ*)
- 19 **Ultrasound**
7:15-10:15 p.m.—Hospital Center at
Orange
(*Diagnostic Radiology Section for
Northern New Jersey and AMNJ*)
- 24 **Lower Back Pain**
8-9 p.m.—Warren Hospital, Phillipsburg
(*Warren Hospital and AMNJ*)
- 25 **Neuropathology Conferences**
8-9:15 a.m.—NJ Medical School,
Newark
(*CMDNJ and AMNJ*)
- 25 **Cardiac Grand Rounds**
3-4:30 p.m.—Medical School, Newark
(*American Heart Association, NJ
Affiliate and AMNJ*)
- May
- 1 **Seminar on Law and Psychiatry**
- 8 3:30-5:30 p.m.—Rutgers Law School,

- 15 Newark
- 22 (*Rutgers University Law School and AMNJ*)
- 29
- 2 Lectures in Obstetrics and Gynecology
8-10 p.m.—Location varies
(*CMDNJ and AMNJ*)
- 2 Endocrinology—Dinner Meeting
6:30-9:30 p.m.—Holiday Inn, East Orange
(*AMNJ Endocrinology Section*)
- 2 Medical Grand Rounds
11:30 a.m.—Rotates between Newark Beth Israel Medical Center, Martland, and East Orange VA Hospitals
(*AMNJ*)
- 2 Personality Disorders
11:30 a.m.-12:30 p.m.—Rahway Hospital
(*Rahway Hospital and AMNJ*)
- 2 Clinical Pathology Grand Rounds
12 noon-1 p.m.—NJ Medical School, Newark
(*CMDNJ and AMNJ*)
- 2 New Developments in Scanning
- 30 Cerebral Vascular Disease
10:30 a.m.-12 noon—St. Mary's Hospital, Passaic
(*St. Mary's Hospital and AMNJ*)
- 2 Psychology of Women—Research
- 16 Psychiatric Dx-Values
- 30 Physicians as Patients and their Families
1-3 p.m.—Ancora Psychiatric Hospital, Hammonton
(*Ancora Psychiatric Hospital and AMNJ*)
- 2 Medical Lecture Series
1-3 p.m.—Christ Hospital, Jersey City
(*Christ Hospital and AMNJ*)
- 16
- 23
- 30
- 2 Estrogen Replacement Therapy
- 9 Dietary Enhancement of CNS Neurotransmitters
- 16 Hazards of Polypharmacy in Psychiatry
- 23 Calcium-Phosphorus Homeostasis and Metabolic Bone Disease
9-11 a.m.—Middlesex General Hospital, New Brunswick
(*Middlesex General Hospital, AMNJ, and AAFP*)
- 2 Grand Rounds and Case Presentations
9 2-4 p.m.—Rotating between Martland, Newark Beth Israel, St. Michael's, St. Joseph's Hospitals and Jersey City Medical Center
(*CMDNJ and AMNJ*)
- 2 Advances in Medicine
9 9:30 a.m.-11 a.m.—Bergen Pines County Hospital, Paramus
(*Bergen Pines County Hospital and AMNJ*)
- 16
- 23
- 30
- 2 Endocrine Conferences
9 3:30-5 p.m.—Rotates between Newark Beth Israel Medical Center, Martland, Hospital and East Orange VA Hospitals
(*AMNJ*)
- 3 Psychotherapeutic Techniques
8-10 p.m.—312 Harding Drive, South Orange
(*Group for Advanced Psychiatric Study and AMNJ*)
- 3 Psychiatric Lecture Series
10 11 a.m.-12 noon—Greystone Park Psychiatric Hospital
17 Psychiatric Hospital
24 (*Greystone Park Psychiatric Hospital and AMNJ*)
- 3 Grand Rounds and Case Presentations
10 4-5 p.m.—Martland Hospital, Newark
17 (*CMDNJ and AMNJ*)
- 24
- 31
- 3 Cardiology Conferences
10 2:15-4:15 p.m.—Deborah Heart and Lung Center, Browns Mills
17 (*Deborah Heart and Lung Center and AMNJ*)
- 24
- 31
- 4 Coronary Artery Disease
8:30-9:30 a.m.—United Hospitals of Newark
(*United Hospitals of Newark and AMNJ*)
- 4 Diagnostic and Therapeutic Problems in Orthopedics
11 7:30-9 a.m.—Alexian Brothers Hospital, Elizabeth
25 (*Alexian Brothers Hospital*)
- 7 Depression in an Adolescent Girl
8-10 p.m.—1046 South Orange Avenue, Short Hills
(*Essex Psychiatric Seminar and AMNJ*)
- 7 Neuroscience Conferences
14 11:30 a.m.-12:30 p.m.—Bergen Pines County Hospital, Paramus
21 (*Bergen Pines County Hospital and AMNJ*)
- 8 Malpractice
- 15 Breast Cancer
- 22 Current Chemotherapy
11 a.m.-12 noon—Greystone Park Psychiatric Hospital
(*Greystone Park Psychiatric Hospital and AMNJ*)
- 9 Suicidology
1:30-2:30 p.m.—John E. Runnells Hospital, Berkeley Heights
(*John E. Runnells Hospital and AMNJ*)
- 10 Case Presentations and Guest Speakers
7:30-9:30 p.m.—Location to be announced
(*NJ Institute of Ultrasound in Medicine and AMNJ*)
- 15 Lung Cancer
11:30 a.m.-12:30 p.m.—St. Mary's Hospital, Orange
(*St. Mary's Hospital and AMNJ*)
- 15 Breast Cancer
7-8 p.m.—Irvington General Hospital
(*Irvington General Hospital and AMNJ*)
- 22 Suicidology
8-9 p.m.—Warren Hospital, Phillipsburg
(*Warren Hospital and AMNJ*)
- 23 Neuropathology Conferences
8-9:15 a.m.—Biomedical Sciences Bldg., NJ Medical School
(*CMDNJ and AMNJ*)
- 30 Cardiac Grand Rounds
3-4:30 p.m.—NJ Medical School, Newark
(*American Heart Association, NJ Affiliate and AMNJ*)
- June
- 1 Adrenal Diseases
8:30-9:30 a.m.—United Hospitals of Newark
(*United Hospitals of Newark and AMNJ*)
- 1 Diagnostic and Therapeutic Problems in Orthopedics
8 7:30-9 a.m.—Alexian Brothers Hospital, Elizabeth
22 (*Alexian Brothers Hospital*)
- 4 Anorexia Nervosa
8-10 p.m.—9 Marquette Road, Upper Montclair
(*Essex Psychiatric Seminar and AMNJ*)
- 6 Endocrine Conferences
3:30-5 p.m.—Rotates between Newark Beth Israel Medical Center, Martland, and East Orange VA Hospitals
(*AMNJ Endocrinology Section*)
- 6 Echocardiography
- 13 Psychotropic Medication
10:30 a.m.-12 noon—St. Mary's Hospital, Passaic
(*St. Mary's Hospital and AMNJ*)
- 6 Depression—Outpatient Rx
- 13 Psychodynamic Therapy for Outpatients
1-3 p.m.—Ancora Psychiatric Hospital, Hammonton
(*Ancora Psychiatric Hospital and AMNJ*)
- 6 Advances in Medicine
13 9:30 a.m.-11 a.m.—Bergen Pines County Hospital, Paramus
20 (*Bergen Pines County Hospital and AMNJ*)
- 6 Medical Lecture Series
13 1-3 p.m.—Christ Hospital, Jersey City
20 (*Christ Hospital and AMNJ*)
- 27
- 6 Grand Rounds and Case Presentations
13 2-4 p.m.—Rotating between Martland, Newark Beth Israel, St. Michael's, St. Joseph's Hospitals and Jersey City Medical Center
(*CMDNJ and AMNJ*)
- 27
- 6 Clinical Pathology Grand Rounds
13 12 noon-1 p.m.—NJ Medical School, Newark
20
27 (*CMDNJ and AMNJ*)
- 7 Psychotherapeutic Techniques
8-10 p.m.—312 Harding Drive, South Orange
(*Group for Advanced Psychiatric Study and AMNJ*)
- 7 Grand Rounds and Case Presentations
14 4-5 p.m.—Martland Hospital, Newark
21 (*CMDNJ and AMNJ*)
- 28
- 7 Cardiology Conferences
14 2:15-4:15 p.m.—Deborah Heart and Lung Center, Browns Mills
21
28 (*Deborah Heart and Lung Center and AMNJ*)
- 12 Lower Back Pain
- 19 Clinical Shock
- 26 PSRO
11 a.m.-12 noon—Greystone Park Psychiatric Hospital
(*Greystone Park Psychiatric Hospital and AMNJ*)
- 14 Lecture Series
8:30-10:30 p.m.—Hackensack Hospital
(*NJ Psychoanalytic Society and AMNJ*)
- 14 Case Presentations and Guest Speakers
7:30-9:30 p.m.—Location to be announced
(*NJ Institute of Ultrasound in Medicine and AMNJ*)
- 19 Peripheral Vascular Disease
11:30 a.m.-12:30 p.m.—St. Mary's Hospital, Orange
(*St. Mary's Hospital and AMNJ*)
- 26 Scanning, New Developments
8-9 p.m.—Warren Hospital, Phillipsburg
(*Warren Hospital and AMNJ*)

Dr. Frederick H. Ambrose

Frederick H. Ambrose, M.D., a member of our Union County component, died on July 5 at his home. Born in 1919 and graduated from Temple University Medical School in 1946, Dr. Ambrose pursued a career in neurosurgery and became board certified in that specialty. He was a Fellow of the American College of Surgeons and a member of the prestigious New Jersey Society of Surgeons. He was affiliated with Alexian Brothers, Elizabeth General, and St. Elizabeth Hospitals in Elizabeth.

Dr. Charles K. Carleton

One of Morris County's senior members, Charles K. Carleton, M.D., of Wharton, died on June 27. Born in Hungary, Dr. Carleton earned his medical degree at the Royal University of Modina in Italy, class of 1927. He emigrated to the United States in the early 1940's and established a general practice in Morristown and in Wharton. He had been affiliated with the Dover General Hospital and Riverside Hospital in Boonton. Dr. Carleton was 79 years old at the time of his death.

Dr. Alphonse V. DelMauro

A member of our Passaic County component, Alphonse V. DelMauro, M.D., of Elmwood Park, died on May 23 in Deborah Hospital, Browns Mills. A native of New Jersey born in 1906, Dr. DelMauro earned his medical degree at New York Medical College in 1932 and practiced general medicine in Paterson

for over 30 years before retiring in 1957. He had been affiliated with Paterson General Hospital. Dr. DelMauro was active in civic and fraternal organizations and had special interest in the local chapter of Deborah Hospital.

Dr. James A. Gribbin

James A. Gribbin, M.D., a well-known Mercer County obstetrician and gynecologist, died in Helene Fuld Medical Center, Trenton, on July 14 after a long illness. A native of New Jersey, Dr. Gribbin was graduated from Hahnemann Medical College in 1941 and took graduate work in obstetrics and gynecology, becoming board certified in those specialties. He was a Fellow of the American College of Surgeons and of the International College of Surgeons and, until illness forced his retirement last year, he was chief of the department of obstetrics and gynecology at Helene Fuld Medical Center. He also was affiliated with Hahnemann Medical College Hospital in Philadelphia and St. Francis Medical Center, Trenton and with the Florence Crittenton Home. During World War II Dr. Gribbin served three years with the 82nd Airborne Division in France, Holland, and Germany. He was 61 years old at the time of his death and was living in Beach Haven Terrace.

Dr. Irvin Morgenroth

Word has been received of the death, at his home on June 13, of Irvin

Morgenroth, M.D., a member of our Camden County component, following a cerebral vascular accident. Born in Austria in 1907, Dr. Morgenroth came to the United States as a child and was educated here, earning his medical degree from Temple University School of Medicine in 1935. He pursued residencies in pediatrics at University of Pennsylvania Graduate School of Medicine and Albert Einstein Medical Center in Philadelphia, and practiced that specialty in Philadelphia until 1956, when he entered a residency program in anesthesiology at Hartford (CT) Hospital. Upon completion he accepted appointment in the department of anesthesiology at the Cooper Medical Center and eventually became chief of that section. Dr. Morgenroth was residing in Pennsauken at the time of his death.

Dr. Raymond Saigh

On July 4, Raymond Saigh, M.D., a member of the Bergen County Medical Society, died in Holy Name Hospital, Teaneck, of a heart ailment. Born in 1921 and graduated from Long Island University College of Medicine in 1944, Dr. Saigh pursued graduate work in pediatrics, becoming board certified in that specialty. He was a Fellow of the American Academy of Pediatrics and director of pediatrics at Holy Name Hospital. He was active in civic affairs, having been school physician in Teaneck and physician to the baby health station there.

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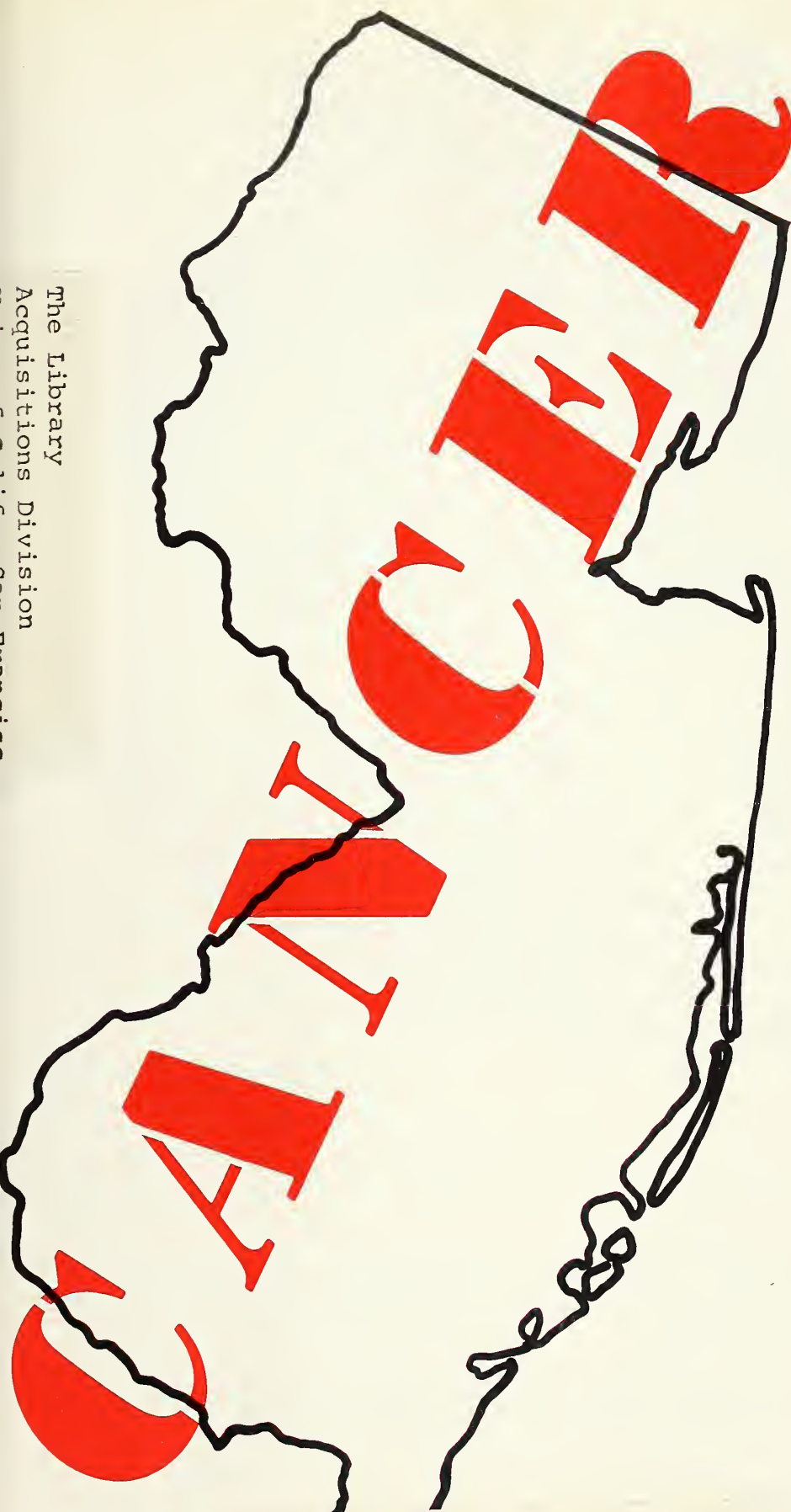
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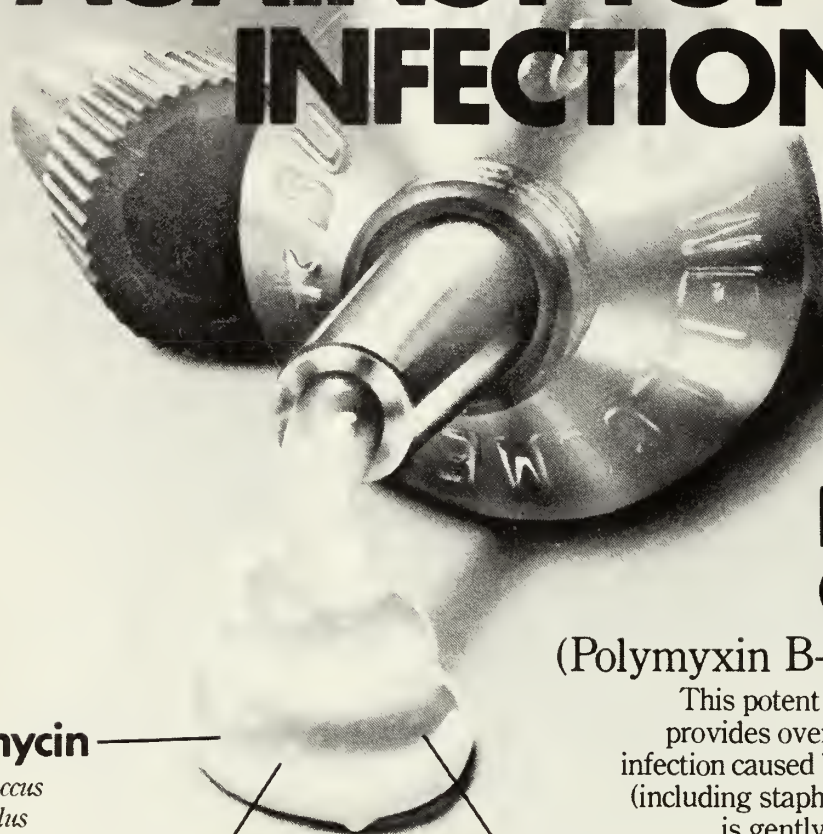
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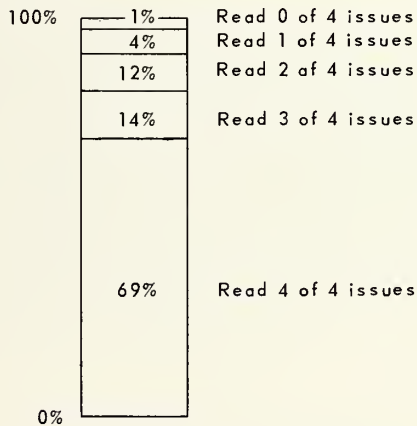
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Readership Survey

In generic terms, a readership survey seeks two kinds of information: feedback for the editorial staff and qualitative and quantitative measurements of interest levels and reading patterns to assist advertisers in their decisions to purchase journal space. In conjunction with the publications of the state medical societies of New York and Pennsylvania, we participated in such an exercise. The data were obtained by a professional opinion research firm which specializes in the health industries and particularly in measurement of readership levels of medical journals.

Several measurements of readership show that *The Journal* of the Medical Society of New Jersey is extremely well read. Ninety-nine percent of physicians in New Jersey read at least some issues, sixty-nine percent read every issue, and eighty-six percent read an average issue.

Interest Levels Demonstrated by Reading Habits



Compared to other studies of this kind, our *Journal* is as well read or better read than most other state medical

journals. Nine out of ten physicians want to continue receiving their copy.

Most of the features of *The Journal* appeal to two-thirds or more of the readers. Respondents were asked to express their interest level as either high, average, or low/none. The following table shows the results for the ten features measured.

Percentage of Readers with High or Average Interest^a

	Percent
Scientific articles	83
Special articles	77
Editorials	76
Case reports	72
Announcements	65
CME information	65
Meetings	65
Therapeutic drug information	64
Commentary	52
Trustees' minutes	25 ^a

The study shows a good overall balance of interest in the features presented. Despite the competition of major national medical journals and specialty journals, the quality of our scientific articles, special articles, and case reports holds up extremely well. This primarily is a tribute to the authors who devote much effort to the material they submit for publication.

The survey will be utilized by the editorial and advertising staff of *The Journal* to make our publication a more effective instrument of communication. However, the personal and individual opinions of our members still remain paramount if *The Journal* is to be responsive to your needs and desires. If you did not participate in this survey and wish to make known your feelings, or wish to have a copy of the complete survey, please write to us directly. A.K.

Comparison with Other Societies Surveyed

	Percent Read Average Issue	Percent Read March 1978	Percent Read 4 of 4	Percent Read 1 of 4
New Jersey	86	82	69	99
Pennsylvania	81	77	63	96
New York	74	73	50	93

^a“Percentage of Readers with High or Average Interest” does not reflect total readership, e.g., “All/Most and Selective Reading Level” of Trustees’ Minutes is 38%.

Molecular Mechanism of Carcinogenesis*

The sequence of events which will result ultimately in a tumor may be analyzed logically and one conclusion easily is reached: cancer derives from a primary event that "transforms" a normal cell into a malignant one, and one or more secondary events at the organismic level which will allow the malignant cell to escape the normal control mechanism at the cell population dynamics level and develop into a malignant population: a tumor.

In recent years it has become possible by the standardization of *in vitro* techniques to investigate the molecular events which "transform" a cell to malignancy.

Viral, chemical, and physical agents have been found to be tumorigenic, and extensive investigations have been carried out to elucidate the mechanism at the molecular levels. The conclusions are the following: the molecular events which bring about malignancy are of a different nature in the case of viruses on one side and chemical and physical agents on the other.

Viruses transform cells to malignancy by addition of viral genetic information to the cell genome. This information is specific and malignancy is achieved by one or more viral genes' products, i.e., viral proteins. These proteins have been identified, and their function is being investigated thoroughly.

Chemical and physical agents induce malignancy instead by "mutating" a cell gene or genes. How many cell genes may be mutated to induce malignancy yet is not known but it will be in a not too distant future.

However, identification of the gene products involved, i.e., the proteins, will have to await the development of a more complete mammalian cell genetics. Therefore, the events at the cellular and molecular level largely are known and the elucidation of the details at the functional level is very near.

Very little progress, if any, has been achieved in the understanding of the secondary level of events, the transition from one or few malignant cells to a tumor. This secondary level may be the most important from a pragmatic point of view. Contrary to popular belief, malignant cells arise very frequently in any given organism and are either kept under control or destroyed. Hence malignancy at the cellular level is a frequent event, while the tumor is a relatively rare one.

The investigation of this secondary level, however, has been impaired by the lack of standardized models at the organismic level. The variants involved are too numerous and some uncontrollable, making it impossible to ask direct questions and obtain significant answers.

Giampiero di Mayorca, M.D.

Prevention of Cancer in New Jersey

The prelude to the 1978 Governor's Conference on Cancer and the Environment was the cumulative evidence of the past several years that New Jersey might have the unwelcome distinction as number one state for cancer mortality in the nation. Whatever the precise data, there seemed to be no question that New Jersey has more than its share of cancer. Governor Byrne recognized the crisis when he appointed a special cabinet committee on cancer. Emergency legislation was introduced and public hearings were held. The New Jersey State Department of Health established a priority for the development of a Cancer Incidence Registry, making cancer a reportable disease. The news media reported almost daily developments and commentary. In the light of all this, the need for the involvement of the New Jersey medical profession is undeniable.

If, indeed, cancer in New Jersey has reached epidemic proportions, then closer examination of our particular environment by the medical profession is essential, if not inevitable. Physicians should not depend upon the morning paper for an understanding of how it is that New Jersey has so much cancer. The time had come, and the 1978 Governor's Conference, an annual tradition of the Medical Society of New Jersey, was the right place to address fully the issue of environmentally related cancer in New Jersey. The proceedings are reported in this issue, beginning on page 743.

From the National Cancer Institute came expertise on epidemiological and experimental methods of detection of environmental cancer hazards and from the Haskell Labora-

tory for Toxicology and Industrial Medicine industrial methods of detection were discussed. The New Jersey State Commissioner of Health and Department staff members, and representatives of the Governor's office, outlined the priorities for State cancer programs and the format for the cancer incidence registry mandated by recent enactment of legislation. Congressman Maguire described his observations as a member of the Congressional Subcommittee on Health and Environment, and the responsibilities of the individual members of the medical profession were suggested in presentations by a practitioner of occupational medicine and an oncologist.

All of this stimulates us to urge each physician to assume greater responsibility in whatever way his practice of medicine will allow. From the recent congressional inquiries into the massive programs of research at The National Cancer Institute and from the blunt admission of NCI director, Dr. Arthur Upton, it is clear that the ultimate answer to cancer cause and prevention is not imminent. The projection of the Nixon administration that massive federal funding could unlock the cancer mystery as expeditiously as the space program could place a man on the moon is not forthcoming. It well may be that the most significant control measures will come from the basic component of the American system of health care, the private practicing physician. He is the one scientist most intimately related to the environment of his patients and his influence may be the most direct instrument for effective preventive medicine. He can anticipate and discourage predictable environmental health threats. His continuous medical supervision can identify health risks to which his patient is exposed and correlate this exposure with

*The author, G. di Mayorca, M.D., a research scientist in DNA and cancer, is professor and chairman of the department of microbiology, New Jersey Medical School, CMDNJ, Newark.

the emergence of relevant disease.

Aware of the risks peculiar to each patient, the physician can prescribe specific diagnostic, therapeutic, and preventive measures as indicated. As Dr. Frederick Cohen observed (page 770), the private practice of medicine is the most cost efficient. State and federal government ultimately may re-

alize that the greatest priority in preventive medicine, cancer control included, is the strengthening of the patient-physician relationship and the private practice of medicine. We shall do our part.

Seymour Charles, M.D.
Lynne B. Harrison, Ph.D.

Humane but Educationally Effective

In this time when "patients' rights" must be a prime consideration of all health professionals, it is astounding that "teaching bedside rounds" still can be a dehumanizing, degrading process. From personal family experience, your editor recently had to share in the embarrassment of the entire medical profession due to the thoughtlessness of a few physician educators and trainees.

The procedure in some university and community hospitals with "teaching programs" has not changed in fifty years. Between five and twenty junior staff physicians, interns, externs, residents at all levels of training, and fellows—sometimes accompanied by nurses, nutritionists, and social workers—descend on the patient's bed. With barely a greeting to the patient, the entourage proceeds to review, *in his presence*, laboratory and x-ray findings, electrocardiograms, and other critical studies. Inevitably, the discussion is couched in medical terminology, which not only is foreign to the patient but frightening as well. Under such circumstances, the patient must feel more like a specimen than a human being. Fragments of sentences like "impending M.I.," the risks of "pump failure" due to "low cardiac index," and "reduced left ventricular ejection fraction" must send chills up the spine of the subject. Rarely does the physician take the time to sit on the side of the bed and translate the medical jargon into meaningful language for his patient. Too often, at this level, the patient is told, "I'll send the reports to your doctor at home."

All of this leaves such patients frightened, angry, and frustrated. They are dissatisfied with the experience and drop

the medical profession another rung in their opinion.

Is it possible to hold teaching bedside rounds in an acceptable and humane way? Certainly! But, the ground rules must be understood by all. It is a legitimate responsibility of the Director of Medical Education (DME) to disseminate such rules of conduct to his colleagues and house staff.

These might include the following:

- (1) Before approaching the bedside, the group should review all the data in a separate conference room.
- (2) Permission should be obtained from the patient for the group to assemble at his bedside.
- (3) If physical abnormalities are to be demonstrated, or numerous examiners are to evaluate the patient physically, prior approval of the patient must be obtained.
- (4) No questions or discussion should be permitted at the bedside unless the patient is a party to the conversation and his feelings are given prime consideration.
- (5) Any speculation as to prognosis, alternative treatments, and so on should be withheld and discussed in the conference room where the group should reassemble.
- (6) One physician, preferably the attending or personal physician, should translate all the pertinent medical data related to diagnosis, studies, treatment, and prognosis directly to the patient. Ample time for questions and discussion should be available.

The process of professional education must remain humane as well as educationally effective.

A.K.

213th Annual Meeting
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GOVERNOR'S CONFERENCE

Environmentally Related Cancer Hazards*

STEWART G. POLLOCK, LLB, Trenton

The Counsel to Governor Brendan Byrne interprets the role of the upper levels of New Jersey government in the control of environmentally related cancer.

Under the leadership of Governor Brendan Byrne, New Jersey has the most extensive statewide cancer program in the nation. Furthermore, the Governor has declared one of the primary goals of his second administration to be the expansion and further intensification of our efforts to understand and reduce the rate of cancer in New Jersey.

The Mason and McKay *Cancer Atlas*, released by the National Cancer Institute in 1974, indicated that New Jersey had the highest cancer mortality rates in the nation for males and second highest for females. The data indicated further that the New Jersey mortality rates for bladder and urinary tract cancer far exceeded the nationwide average, with the rates in Salem County topping the more than 3000 counties in the nation. Cancer mortality for almost all gastrointestinal tract organs was very high in New Jersey, especially for colorectal cancer. The mortality rates for respiratory tract cancers also were high, particularly in Passaic, Bergen, Essex and Hudson Counties. And New Jersey ranks third for breast cancer, with especially high rates in counties near New York City and Philadelphia.

INFERENCES ABOUT CAUSE

These cancer mortality statistics raised the specter of a serious problem in New Jersey, but failed to indicate what inferences could be drawn about possible causes. We were left to ponder: What is it about New Jersey that has produced these disturbingly high cancer mortality statistics?

Could it be the fact that New Jersey has the most densely urbanized population in the country? Or that the state has one of the lowest land elevations above sea level and a turnpike which carries some of the heaviest traffic in the world through the middle of this minimum-elevated, densely populated area? Or perhaps the fact that New Jersey is one of the most industrialized states in the country, with 26 percent of the workforce employed in manufacturing, 17 percent of that in chemical manufacturing. Yet, a quarter of all the land in the state is still open farmland—and some of these areas have excessive cancer mortality rates also.

The possibility that there may be a direct causal relationship or a synergistic relationship between these environmental features of New Jersey and its extremely high cancer mortality is a hypothesis which needs much refinement.

Furthermore, environmentally-related cancer hazards include more than the possibility of carcinogenic substances in the general air and water of the state. There is also the possibility that exposures to cancer-causing agents in certain occupational environments may be contributing to the state's high cancer mortality rates. For instance, unprotected asbestos workers are at an increased risk of getting lung cancer. The risk of lung cancer is also increased by cigarette smoking. The combination of smoking with a working environ-

*Keynote address at the Fourth Annual Governor's Conference of the Medical Society of New Jersey, May 6, 1978, Atlantic City. Mr. Pollock is Counsel to Governor Brendan Byrne.

ment involving potential exposure to carcinogenic substances further increases the risk of lung cancer. For the unprotected asbestos workers who also smoke, the risk of lung cancer is 90 times greater than that of the general population.

Other hypotheses about the causes of cancer include socioeconomic factors, dietary factors such as certain food additives, the use of certain drugs such as diethylstilbestrol (DES), exposure to radiation from the sun or from nuclear plants or medical application. Those factors are not unique to New Jersey, but may be acting in concert with other environmentally related hazards in the state.

In any case, it is clear that cancer is not simply an issue of health statistics, but a serious environmental, industrial, and agricultural concern.

CABINET LEVEL CANCER COMMITTEE

Recognizing the complex and inter-departmental nature of New Jersey's cancer problem, Governor Byrne created a permanent Cabinet Level Committee on Cancer Control by Executive Order #40 in May, 1976. The Cabinet Committee draws upon every major state department which has a role to play in the cancer control effort, including the Departments of Agriculture, Education, Environmental Protection, Health, Higher Education, and Labor and Industry. It is my privilege as Counsel to the Governor to act as Chairman of the Committee.

The primary goals of the Cabinet Committee are to develop and implement a comprehensive program to refine our understanding of the cancer problem in the state and to control and, if possible, reduce the rate of cancer in New Jersey. This is no small task! To do this, the Cabinet Committee is charged with coordinating appropriate state cancer control projects with the private sector, assisting in the development of new projects, reviewing pending legislation and administrative action, and identifying additional federal and private sources of funds to support an intensified community-based cancer control effort.

A Cabinet Level Committee to coordinate state government resources and to reach out to private and federal resources is unique among the fifty states. The Committee has undertaken a joint effort to use applied research to identify high-risk populations, the presence of cancer-causing agents in the environment with priority to high-risk areas, cost-effective medical surveillance techniques for populations at risk, alternative or modified production processes or procedures or other methods of protecting workers from occupational exposure to carcinogenic substances, and appropriate methods of reducing significant community exposure to carcinogenic substances.

Based on the results of this research, the Committee is developing a program to minimize the level and extent of carcinogenic exposure by reducing hazardous emissions and exposures both in the workplace and the general environment, reducing inappropriate uses of diagnostic radiology, educating high-risk groups and health care providers to the potential synergistic effects of exposure to certain occupational hazards and smoking and by reducing the extent of cigarette smoking.

Finally, this Committee hopes to encourage and assist professional organizations, health care planners and providers, and the state's medical institutions in the establishment of regional networks for definitive diagnosis, evaluation and treatment, and rehabilitation and continued care for these high-risk populations. We also hope to reach out to

other organizations, including voluntary public interest groups and labor unions, to help us to combat the cancer problem.

NEW JERSEY CANCER CONTROL PROJECTS

Since May 1976, over twenty state and federally funded cancer control projects have been initiated in New Jersey. These include: a study of the relationship of occupational experiences and bladder cancer, funded by the National Cancer Institute; a study of the relationship between in-plant workers using arsenical pesticides and liver cancer, funded by the Environmental Protection Agency; an on-site health and safety consultative services project, funded primarily by the U.S. Department of Labor; and an industrial-use survey to determine the source and extent of emission of selected carcinogens, funded partially by the Environmental Protection Agency (EPA) and HEW and conducted jointly by the New Jersey Department of Environmental Protection (DEP), the Department of Labor and Industry, and the occupational health program of the Department of Health.

The ongoing cancer control program also includes the following state-funded projects: the establishment of a cancer registry to obtain information on the incidence of cancer; a cancer-related occupational health program; a pilot occupational health project; a study of the statistical correlations between various factors and cancer mortality rates; several programs to reduce excess exposure to radiation and ground-water, surface-water, air, and marine life monitoring and testing for carcinogens.

Over \$1.5 million of state monies and a nearly equal amount of federal funds are involved *this year alone* in this continually intensifying cancer control program.

Two years of study have not been sufficient to determine definitively the sources and causes of cancer in New Jersey. We have, however, identified certain high-risk populations and areas which indicate the directions for future activities. Furthermore, the Departments of Health and Environmental Protection have built up their capacity over this time period to allow them to respond immediately to situations such as the Rollins Chemical plant explosion and the cluster of leukemia cases in Rutherford.

Following an explosion at the Rollins Chemical Waste Detoxification and Disposal plant, the swift arrival of the Departments of Health and Environmental Protection made it possible to take the necessary environmental samples to determine if incomplete combustion had taken place to produce PBB's,^a a known carcinogen as well as a respiratory irritant. Also, those immediately exposed to the fumes were brought systematically and swiftly into medical surveillance. Commissioner Finley of the New Jersey Department of Health, within five days, was able to announce that there were no dangerous traces of PBB's^a in the soil or water.

Following reports of numerous cases of leukemia in Rutherford, the Department of Health immediately investigated and confirmed within a week that there was an unusually large cluster of leukemia cases, specifically in the five- to 19-year-old age group at the Pierpont School in Rutherford.

The preliminary analysis has been followed by in-depth interviewing of the families concerned by Dr. Ronald Altman, the epidemiologist at the New Jersey Department of Health, and by extensive testing by the Department of

^apolybrominated biphenyls

Environmental Protection of the air, water, and sources of radiation in that specific area. I have been advised that the information obtained to date does not indicate any significant correlation with any specific environmental factors. When completed, these findings will be made public.

CRUSADE AGAINST CANCER

The statistics, activities, and events I mentioned impel us to intensify our cancer control efforts. The crusade against cancer is waged with painstaking scientific analysis and patience. We are concerned with a disease that often takes ten to thirty years to become manifest—a disease which can take many forms, ranging from leukemia to lung cancer, which has an incredible multiplicity of possible causes, and which involves the premature loss of enormous numbers of lives. The American Cancer Society estimates that cancer will develop in 26,000 New Jersey residents this year alone and cause the death of 15,000 residents.

The battle against cancer is going to be a long and arduous one, requiring all of the resources which we can muster. We recognize that the present efforts of the Cabinet Committee on Cancer Control must include the greatest possible coordination with existing efforts of interest groups and reliance on sources of professional and technical expertise. In the two months that have transpired since my appointment as Counsel to Governor Byrne, the Committee has been meeting more frequently to assess its needs and limitations. The Governor shortly will be announcing the formation of an

advisory council to provide this additional expertise for the Cabinet Committee.

In addition, the Cabinet Committee hopes to announce soon new initiatives in the area of smoking prevention and education programs, cancer screening and early diagnosis programs, and the expansion of comprehensive occupational health programs for high-risk populations.

Every one of us can add something to this crusade against cancer; something as simple as recognizing that smoking may be hazardous, not only to the smoker but perhaps even to those around him. Furthermore, physicians who maintain careful records on the smoking, dietary, and occupational background of their patients may provide crucial data for the better understanding of this multifaceted disease . . . cancer.

CONCLUSION

The Governor has dedicated the best resources that he has available to fight the problem of cancer in our state—his key cabinet officials and the competent professionals stand behind them. But we need the cooperation of the state's doctors, industry, labor force, voluntary organizations, parents, and children.

We obviously cannot expect instant answers this year or next. I am convinced, however, that if we face the problem with sufficient resources and determination, we probably can find the causes and perhaps the methods for preventing cancer too.

Detection of Environmental Cancer Hazards: Epidemiologic Methods*

ROBERT N. HOOVER, M.D., Bethesda, Maryland

The majority of human cancers are environmentally caused and hence are preventable. The epidemiologic method is a major technique to identify causative agents. The clinician can uncover clues to etiology by careful observation of patients and can assist by cooperating with the investigative epidemiologist.

It is widely accepted that the majority of human cancers are environmentally caused and hence preventable. It is important to keep in mind the definition of environment. Here environment means anything other than a person's genetic makeup. This includes exposure to occupational factors, toxic chemicals in the general environment, natural and artificial constituents of the diet, drugs, and cigarette smoking, and to other exposures related to personal habits. The environmental origin of most human cancer is apparent from studies of geographic variations in cancer incidence and mortality among genetically similar populations, and the almost universally observed movement of cancer incidence rates in migrant populations away from the rate prevailing in their homeland and toward the rates prevailing in their adopted homelands. It has been fashionable among some to attempt to quote a percentage of human malignancy that can be attributed to environmental exposures. Based on our current level of understanding of the carcinogenic process, this is a naive and misleading exercise. Like most other diseases, cancer is due to a complex interaction of many causal factors. Based on what we now know, it is reasonable to contend that nearly all human cancers are environmentally induced and, at the same time, that close to 100 percent of human cancers are influenced by host factors. In other words, almost all of human cancer requires exposure to a carcinogenic agent by an individual who is susceptible to the carcinogenic action of that agent.

Supporting this opinion are the observations that it is extremely rare for a genetic condition to result in a 100 percent attack rate of cancer, and equally as rare for an environmental exposure to cause a 100 percent attack rate in all those exposed. This is not a new concept for the same holds true for every infectious disease. A person does not develop clinical tuberculosis without exposure to the tubercle bacillus. Just as certainly, this person does not become a clinical case of tuberculosis without possessing the complex web of nutritional, immunologic, and other host factors which made him susceptible to the action of the bacillus.

If all this is so, then there are two potential avenues for preventing human cancer, just as there are the same two avenues for preventing infectious diseases. One is to manipulate the environment in order to prevent exposure to carcinogenic agents and the other is to manipulate the host's susceptibility to the carcinogenic potential of environmental agents. Currently, we do not prevent cholera in this country by immunization but by keeping people from drinking sewage. On the other hand, we do little to prevent environmental exposure to the polio virus, but attempt to alter our children's susceptibility to this agent. While manipulation of

*Presented at the Fourth Annual Governor's Conference of the Medical Society of New Jersey, May 6, 1978, Atlantic City. Dr. Hoover is Head of the Environmental Epidemiology Branch, National Cancer Institute, National Institutes of Health, Bethesda, Maryland. He may be addressed there—Room C307, Landow Building.

host susceptibility eventually may be realized for cancer, there is no evidence that such possibilities exist in the near future. On the other hand, there is a growing body of evidence that interruption of exposure to carcinogenic agents can result in cancer prevention *now*. Therefore, it seems appropriate to place a heavy emphasis on the identification and removal of carcinogens in our environment.

One major mode of identifying disease-causing agents is the *epidemiologic method*. As you may recall from your sophomore medical student days, epidemiology is the study of the distribution and determinants of disease frequency in humans. In general, epidemiology affords two methods to evaluate the influence of environmental exposures on the development of cancers. One method is *descriptive epidemiology*, which attempts to evaluate the risk of various diseases in large population groups about which something is also known with respect to potential causes of these diseases. These population groups can be defined in a number of ways, e.g., by place of residence, year, race, age, and so on. The other method available is *analytic epidemiology*. In these studies attempts are made to obtain information on the possible causes of disease in specific individuals. By aggregating large numbers of individuals on which this information has been collected, a more precise determination of causal factors can be made than can be done by the more descriptive approaches.

Rather than go into a didactic discussion of epidemiologic methods which will just as certainly put you to sleep now as it did when you were in medical school, I will illustrate these two major methods in epidemiology (descriptive and analytic studies) by referring to specific examples in which I have been involved in the past several years.

DESCRIPTIVE EPIDEMIOLOGY

As mentioned, descriptive epidemiology relies on information from large population groups identified by place of residence, year, race, age, or other variables. Specific examples involving variation by time, geography, and race point out some of the values of these methods as well as some of the pitfalls.

With respect to time trends, persons who de-emphasize the impact of chemical exposures on human cancer—either in the occupational or general environmental setting—often point out that since the rapid expansion in the manufacturing and use of man-made chemicals in this country, the overall incidence of cancer has risen only slightly in males and actually has declined in females. However, it seems unwise to use these observations to discount the influence of man-made chemicals. It is wrong to suggest that all cancer combined (or even all cancer minus lung cancer) is a meaningful measure of disease as far as etiologic research is concerned. It is wrong to imply that somehow we know the base-line level of cancer risk in the absence of all newly produced chemicals. And finally it is wrong to imply that the effects of newly produced chemicals could be gauged through current rates for cancer. The slight decline in cancer rates once lung cancer is excluded is due largely to the sharp decrease in the incidence of stomach cancer in both sexes, and invasive cancer of the uterine cervix in females. There is currently no reason to believe that either of these impressive declines is due to the proliferation of man-made chemicals in our environment. Cancer (even cancer excluding lung cancer) is certainly not one disease. Grouping diseases which have different causes greatly impairs our ability to identify the origins of specific illnesses. For example, while the total cancer incidence rates

(minus lung) declined slightly between the late 40's and the early 70's, the following trends have been observed for specific sites of cancer. Cancer of the esophagus has risen by 117 percent in nonwhite males and 127 percent in nonwhite females. Cancer of the intestines has risen by 19 percent in white males and 68 percent in nonwhite males. Cancer of pancreas has increased by 16 percent in white females, 20 percent in white males, 42 percent in nonwhite males, and 100 percent in nonwhite females. Malignant melanoma of the skin has increased by 85 percent in white males and 42 percent in white females. Prostatic cancer has increased by 21 percent in white males and 57 percent in nonwhite males. Bladder cancer has increased by 24 percent in white males and 104 percent in nonwhite males. Cancers of the kidney, renal pelvis, and ureter have increased by 58 percent in white males and 44 percent in nonwhite males. Cancer of the thyroid gland has increased by 50 percent in white females and 100 percent in white males. The incidence of lymphoma has increased by 39 percent in white males, 49 percent in white females, 74 percent in nonwhite females and 82 percent in nonwhite males. Other trends might be cited, but I think this should be sufficient to illustrate the profound increases in the risk of certain cancers just in the period from 1947 to 1970. We hope these epidemiologic observations will point to hypotheses that we can test in more analytic studies.

One should not take much solace in the lack of increase for other specific sites. Since we are largely ignorant of the causes of most cancer, we really do not know what to expect the trend of cancer to be in the absence of the recent chemical revolution. For example, the stable incidence rates for endometrial cancer between 1947 and 1970 were interpreted as exonerating a newly introduced carcinogen. That evaluation was subsequently shown to be profoundly wrong, since cancer of the endometrium now clearly has been linked with the use of a particular pharmacologic agent—estrogens for the treatment of the menopause. The unchanging time trend prior to the 1970's masked this problem for several reasons, particularly the rising rate of elective hysterectomy over the past 30 years, which effectively reduced the total number of women at risk of developing this tumor. Lastly, the interval between the time that a hazardous exposure occurs and the time that it is manifest by the diagnosis of a tumor is usually quite long. For some very potent occupational bladder cancer carcinogens this average latent period was about 18 years and, for some less potent occupational carcinogens, it has been estimated to be in excess of 40 years.

Another descriptive method for evaluating the influence of various factors on the risk of cancer is geographical variation in the frequency of cancer. Several years ago we published a very large book of numbers. This book contained the age-adjusted rate for each of four race-sex groups for 35 different sites of cancer in each of the 3,056 individual counties of the United States. We felt that this publication might be a major research resource for identifying cancer patterns that might lead to identification of specific causes, but it hit the research community with a resounding thud. While we began to work with the material, very few other people did. We then tried to turn some people on to these data by illustrating them in the form of maps and we produced two atlases of cancer mortality by county in the United States. The rest is history, well known to all of you. These illustrations of the non-random distribution of cancer risk in this country have had an enormous effect on the research community, governmental agencies, and even the general public. Some of the sequela may have been due to inappropriate interpretations of these

maps. However, for the most part, the reactions and interests generated by these maps have been one of the healthiest spurs to disease prevention that have occurred in some time in this country.

Figure 1 illustrates the distribution of cancer mortality rates in white males for all sites of cancer combined. As you will note, New Jersey is well represented with a number of counties with rates in the top 10 percent of all counties in the country. The general pattern of distribution of counties with high rates that is illustrated—concentrated in the northeast, urban centers in the midwest, and in some southeastern and southern coastal areas—reflects primarily the distributions for two of the more common sites in males, i.e., lung cancer and colon cancer. High rates in the northeast and urban midwest also characterize the situation for females with respect to colon cancer and breast cancer. However, each specific site of malignancy has its own characteristic distribution.

Figure 2 illustrates the distribution of cancer death rates for malignant melanoma of the skin. High rates predominate in the south, and low rates in the north. In fact, there is almost a linear relationship between the magnitude of the rate and the latitude in which the county is situated, illustrating the underlying association of this tumor with exposure to ultraviolet irradiation in the form of sunlight. Figure 3 illustrates the distribution of mortality rates for stomach cancer among white males. The two major high-risk areas are in the northern portion of the north central region of the United States and in the southwestern states. These areas correspond with those areas where migrants from countries experiencing very high stomach cancer rates have settled (Scandinavia, Germany, Austria, and Mexico). Figure 4 illustrates the mortality rates among white males for cancers of the urinary bladder. As you will note, New Jersey stands out particularly prominently in this map. Nineteen of the twenty-one counties in the state of New Jersey have rates for bladder cancer which place them in the top 10 percent of all counties in the United States. As you are well aware, the state of New Jersey is also the state with the highest concentration of the chemical industry. In fact, correlating industrial patterns on the national level with the rates of bladder cancer reveals a strong and consistent relationship with the presence of the organic chemical industry. Since bladder cancer is the tumor most closely linked to occupational exposures and many of these are in the chemical industry, New Jersey's high rates may be explicable on this basis.

ANALYTIC EPIDEMIOLOGY

While descriptive epidemiology can give us clues to potential causes of disease, it remains for the much more refined techniques of analytic epidemiology to provide persuasive evidence of causality. While epidemiology in general, and analytic studies in particular are enjoying renewed emphasis, the number of epidemiologists and good analytic studies in the area of environmental cancer still remain quite small. Therefore, we can consider the whole area of environmentally induced malignancy as almost unexplored territory, as only a few of the hypotheses raised in descriptive studies yet have been evaluated. Two recent studies in which our branch has been involved, however, illustrate the need for this type of study. The first field study that was initiated in response to the geographic distribution by county was a study designed to investigate the abnormally high rates of lung cancer in the predominantly rural areas of the coastal southeastern United States. An intensive interview study of lung cancer patients

and the comparison individuals from this region has revealed that a portion of the excess appears to be attributable to only very brief exposures that these individuals had working in shipyards during World War II. Of particular interest is the observation that the excess appears to apply to a number of different jobs within the shipbuilding industry, not simply those that involved the application of asbestos. Another analytic epidemiologic study which currently is being conducted involves New Jersey in a major way. This study is a case-control interview study of all newly diagnosed bladder cancer cases in ten separate areas of the United States—including the entire State of New Jersey. The interview involves obtaining information on the use of tobacco products, life-time occupational histories, life-time residence histories, exposures to artificial sweeteners, and a number of other potentially hazardous exposures. It is our hope that this study will reveal specific, potentially preventable, exposures which may be responsible for a portion of the bladder cancer excess as seen in the State of New Jersey and elsewhere.

In evaluating the various methods that epidemiology has to identify environmental hazards, it is important to recognize both the strengths and the weaknesses of the epidemiologic approach.

STRENGTHS AND WEAKNESSES OF EPIDEMIOLOGY

The strengths of the epidemiologic method are two-fold. First of all, this method allows the direct measurement of the risk of cancer due to an exposure in a *human* population. It thus can identify causes of cancer in *humans* that are associated with intermediate or high levels of risk. Secondly, there is a much less obvious role and strength of the epidemiologic method. That is, these kinds of studies can allow someone to gain insights into the basic mechanisms of a disease causation (for cancer, the mechanism of carcinogenesis).

If these are the strengths of epidemiology, then what are its weaknesses? There are at least five major weaknesses to the epidemiologic approach. First of all, as you may have inferred from my emphasizing that epidemiology was reasonably strong in identifying intermediate and high levels of risk, it is quite weak at identifying the causes of very *low* levels of risk. Very small differences in risk between a group exposed to some substance *versus* that in a group not exposed to it could be due to a variety of reasons. For example, chance or other differences between the exposed and unexposed which we either do not know about or which we cannot control adequately. Because of this, it becomes next to impossible to say with any assurity that a very low level of risk is caused by a similarly low-level exposure to some substance. What do we mean by low level of risk? The lowest excess cancer risk that is directly observable in a group of exposed individuals and is generally accepted as being due to that exposure and not some other factor is the 30 percent excess risk of childhood leukemia among children who were exposed to radiation *in utero* in the last trimester of pregnancy (pelvimetry). Indeed, it has taken us some 20 years to become reasonably convinced of this 30 percent excess risk.

The second weakness of the method, and perhaps its most important weakness, is what is referred to as latent period or induction—incubation period. This is the interval between exposure to a cause of a disease and the actual manifestation of the disease itself. For cancer-causing exposures these latent periods are quite long—from five years to over 50 years.

CANCER MORTALITY, 1950-69, BY COUNTY
ALL SITES COMBINED
WHITE MALES

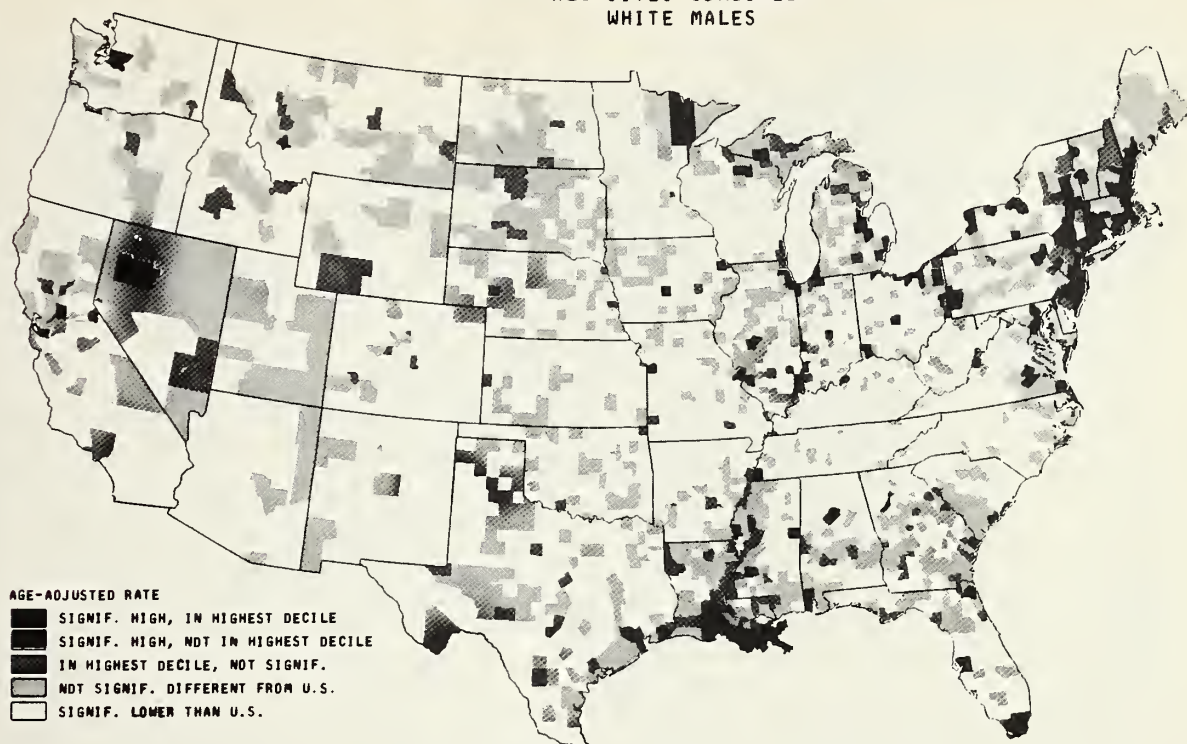


Figure 1

CANCER MORTALITY, 1950-69, BY STATE ECONOMIC AREA
MELANOMA OF SKIN
WHITE MALES

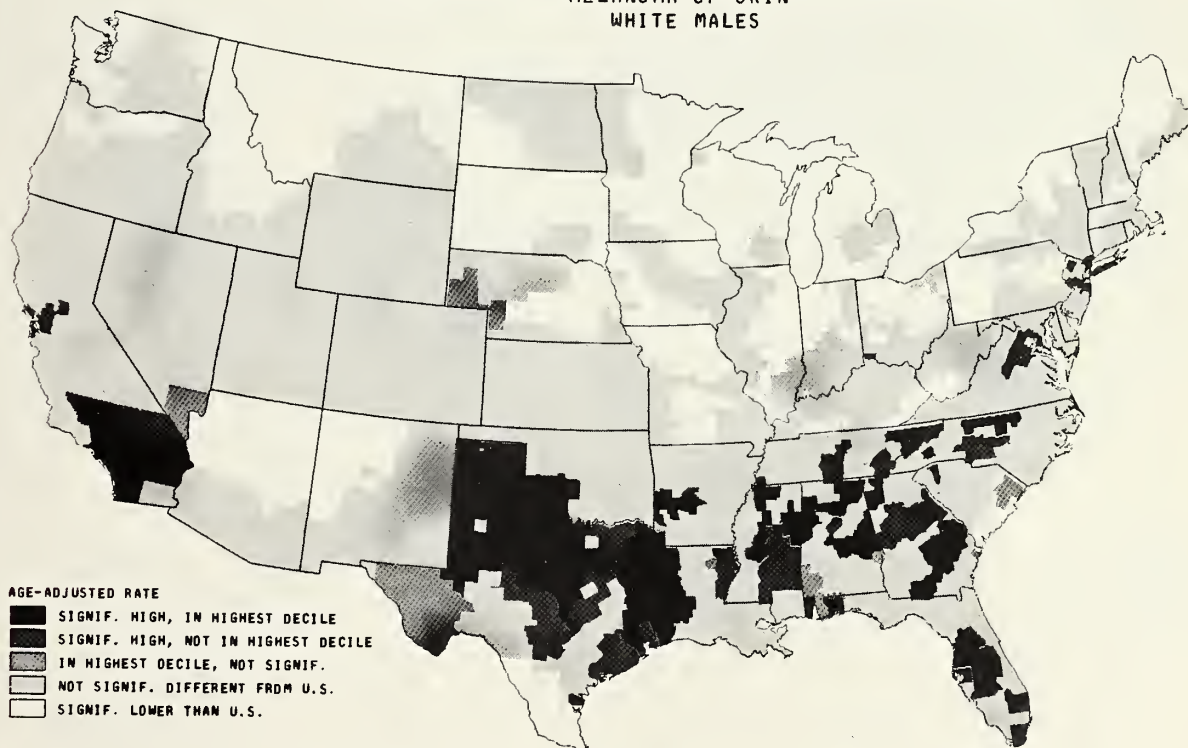


Figure 2

CANCER MORTALITY, 1950-69, BY COUNTY
STOMACH
WHITE MALES

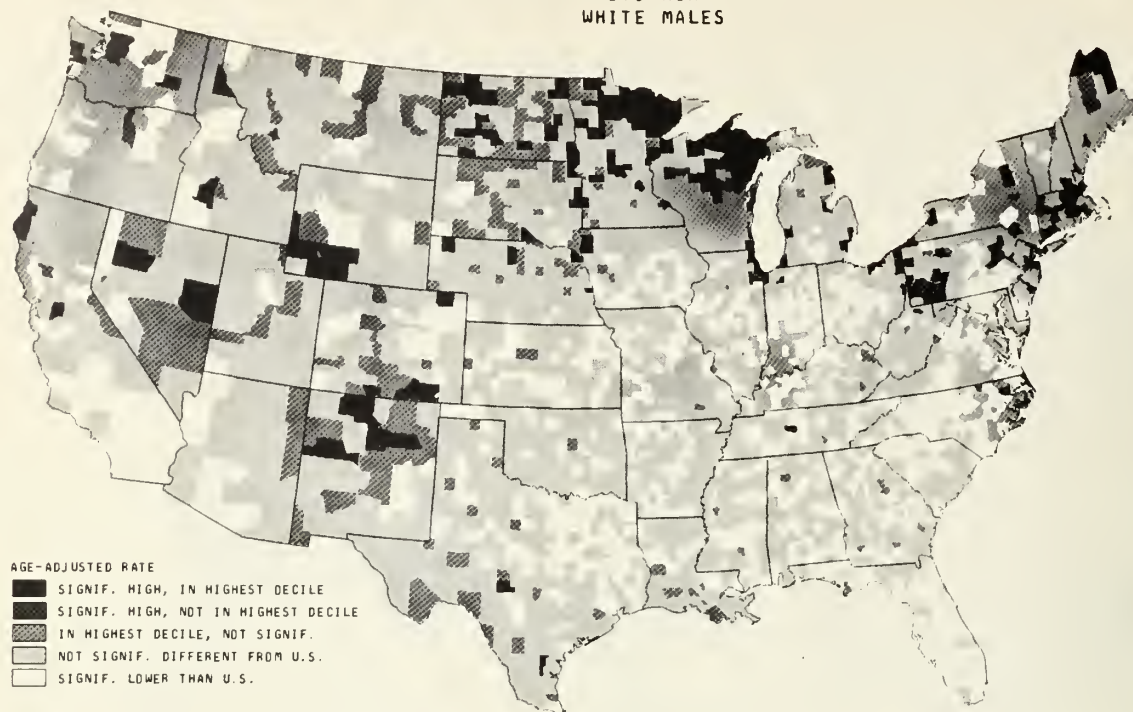


Figure 3

CANCER MORTALITY, 1950-69, BY COUNTY
BLADDER
WHITE MALES

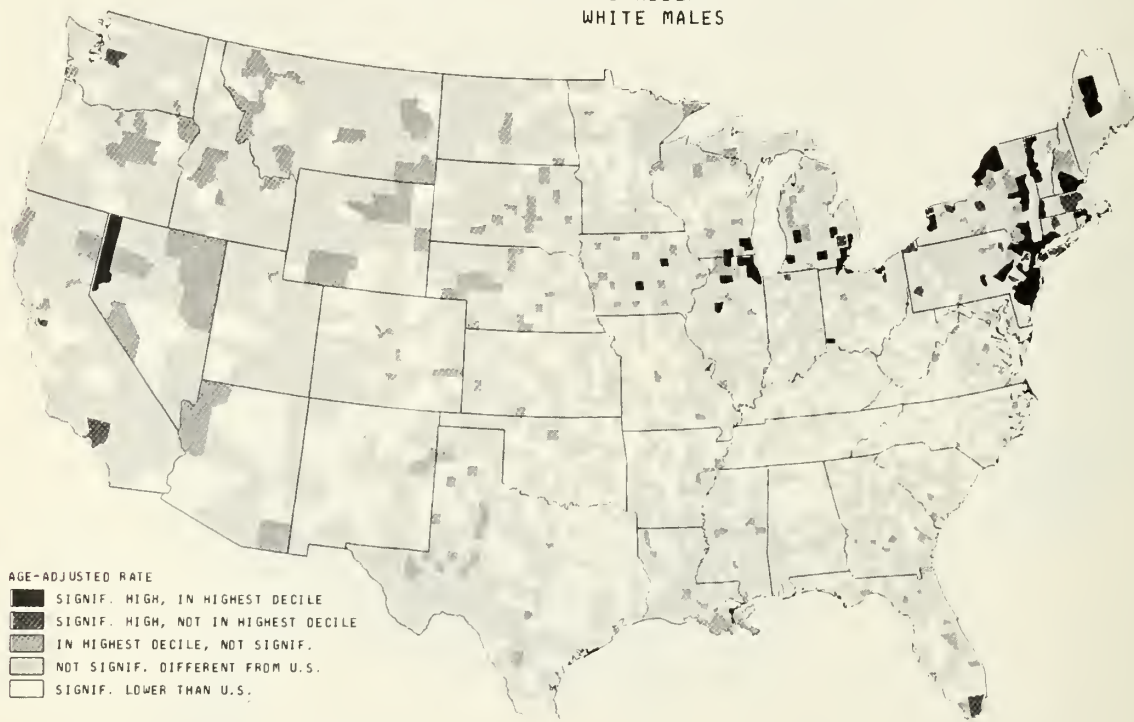


Figure 4

The third weakness of the method is the lack of specificity of exposure. Usually epidemiologists study the effect of exposure to mixtures of chemicals or other agents rather than pure exposures to a single toxic substance.

The fourth weakness is the inability to control the unknown risk factors for the disease in question. In an experiment we hope that the randomization procedure introduces some control for unknown factors. In observational studies, we can control for known confounding factors, but obviously cannot guarantee control for unknown confounders.

The last weakness of the approach encompasses the practical problems involved in epidemiology. In order to function effectively an epidemiologist needs to have access to appropriate information on large groups of people. Sometimes this is possible, but sometimes the information just does not exist. Furthermore, there currently is a lack of enough competent epidemiologists even to evaluate adequately the information that does exist.

ROLE OF CLINICIAN

What does all of this mean for the practicing physician in the State of New Jersey? As illustrated, New Jersey has been prominent in some of our undertakings. It reflects the same trends that we see in a number of urbanized, industrialized areas in this country for a number of cancer sites; in addition, for some cancers New Jersey actually seems to be particularly exemplary of some problems. But what does it mean for the practicing physician? Here is where I have an opportunity to do a little proselytizing. While all of you cannot participate in the laboratory animal approach to identification of cancer hazards, all of you can participate in the epidemiologic approach. If there is one thing that we have learned in the course of identifying causes of cancer and birth defects in humans, it is that the most productive source of clues for these agents is the alert clinician. Every clinician should be an etiologist in his own right. The observation of the relationship between aromatic amines and bladder cancer was originally that of a German surgeon, who noticed an abnormal frequency of bladder cancer occurring in the workers in one specific plant. You may be aware of the

vinylchloride story, which was the result of an alert observation by an industrial physician working for the B.F. Goodrich Company. The identification of diethylstilbestrol as a transplacental carcinogen was the result of an astute observation by an inquisitive gynecologist at the Massachusetts General Hospital. There are many other examples, but the point is clear. The practicing physician should keep etiology as well as therapy in mind. He should be attuned to the kinds of patients he sees, their occupations, their personal habits, their dietary habits, the drugs they take, and so on. An alert and inquisitive clinician can be one of the most productive epidemiologists.

The second way in which clinicians can be involved in identifying environmental causes of disease is by active cooperation with investigators who are pursuing some of the more systematic approaches. I mentioned that part of our systematic evaluation of geographic patterns of cancer in this country involves getting into specific analytical studies in selected high-risk areas in order to follow up on the clues that have been generated. One of our first attempts in this direction is the investigation of bladder cancer in the State of New Jersey, in collaboration with your State Health Department. The response of the medical community of this State has been remarkably gratifying. You all have shown more interest and concern than we had hoped. Pathologists have opened their log books to identify cases. The urologists and family practitioners have granted permission to approach their patients for interviews. I thank you for that cooperation and encourage you to persist in it.

CONCLUSION

Those of us who pursue systematic approaches are totally dependent on the good will and cooperation of those physicians who actually see the patients and make the diagnoses. We only can function and only can identify preventable causes of disease with your cooperation. Without it we cannot do anything. I hope you will continue to support these efforts, as I think it is in the true spirit of concern for patients, as well as for society, which is a feature of physicians in general and this State Medical Society in particular.

Detection of Environmental Cancer Hazards: Experimental Methods*

UMBERTO SAFFIOTTI, M.D., Bethesda, Maryland

Experimental carcinogenesis research is attempting to identify cancer threats to patients through a variety of animal systems, and through biological studies at the tissue, cellular, and molecular levels. Some roles of the practicing physician in cancer prevention are described.

This session is devoted to a discussion of the detection of environmental cancer hazards and is trying to answer the question "what are the health threats to your patients?" Those cancer threats that already have affected a population for a long time may be identified by careful epidemiological investigations, as discussed by Dr. Hoover. Relatively few such good epidemiologic studies have been undertaken so far. Only about 30 agents have been identified as carcinogenic by direct studies in human populations including both occupational and other environmental carcinogens, (Saffiotti and Wagoner,¹² 1976; Hiatt, Watson and Winsten⁵ (1977; Tomatis *et al.*¹⁴ 1978). Are these the only threats to your patients? Clearly not, as gradually is demonstrated by the progressive discovery of more and more causative agents which previously went unrecognized. In this respect I believe that we have observed only a portion of the tip of the iceberg so far.

Is there a way to identify these cancer threats to your patients before a large enough number of them develop cancer to provide the evidence? Progress in experimental carcinogenesis research fortunately has provided a solid "yes" as an answer. Experimental methods indeed have developed in such a way that the characteristic interaction of certain chemicals with cellular targets, which transforms normal cells into cancer cells, can be well identified and reliably reproduced by a number of biological model systems. These include a variety of animal systems in which cancer

can be induced by chemicals in a broad spectrum of target tissues, under well-controlled experimental conditions.

ANIMAL MODELS

Work of the last decade in particular has strengthened our confidence in the validity of the animal models, since we have been able to reproduce in laboratory animals nearly all the major forms of human cancer by means of chemical induction. The resulting cancers show a remarkable similarity to their human counterparts in their histopathogenesis and their structure. Examples of the major forms of cancer for which good animal models have been developed by chemical induction include cancer of the bronchus, larynx, esophagus, stomach, large bowel, pancreas, liver, kidney, bladder, uterus, breast, thyroid, as well as skin cancers and melanomas and many others, including neoplasms of mesenchymal origin such as angiosarcomas, osteosarcomas, nervous tissue tumors, lymphomas, and leukemias. That this wide range of human cancer types can be reproduced in other mammalian species by means of chemical induction

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⁵Robert Hoover, M.D., "Detection of Environmental Cancer Hazards: Epidemiological Methods," page 746, this issue.

gives, I believe, strong supportive evidence for the chemical origin of a large proportion of human cancers.

Animal experimentation with chemical carcinogens has led us to the development of bioassay methods for the detection of carcinogenic effects of environmental chemicals using long-term animal tests. These test methods have been standardized to a large extent following a great deal of discussion, consultation, and advice by experts at the national and international level (Berenblum,¹ 1969; Sontag, Page and Saffiotti,¹³ 1976).

The detectability of the carcinogenic activity of a test chemical in the animal bioassays is limited severely by the number of animals used. The standard bioassay using both sexes of two species and two dose levels, with 50 animals in each of the resulting eight groups, plus the necessary controls, can detect tumor induction levels of five to ten percent or higher, but is quite incapable of detecting an effect at the one percent level or below. For this and other reasons, these are by no means the most stringent possible tests. They are scanning tests, designed only to detect high-level effects, not those levels of effect that still would be a source of major concern in the population, such as 1:10,000 or 1:100,000. In this respect I believe that any agent which is found carcinogenic by such tests, even at high doses, must be considered a "strong" carcinogen.

As far as test doses are concerned, it is important to note that the reason we constantly have recommended testing protocols that include the "maximum tolerated dose" is the need to extend the observations as much as possible so as not to miss an effect that only may be evident at the higher levels because of quantitative limitations. It is also important to emphasize that it simply is not true that carcinogens are effective only at "unrealistically" high levels. In fact, a number of environmental carcinogens are quite effective when tested at levels well below those still allowed for human exposure (e.g., DDT is allowed at seven ppm in certain food items and was found to be carcinogenic at two ppm; aflatoxin B₁ is allowed at 20 ppb in food items and is carcinogenic when tested at one ppb).

HUMAN CORRELATION

People are exposed to a wide range of carcinogens from the general environment, from consumer products, from food and water contaminants, and from occupational exposures. The action of a single carcinogen needs to be viewed as contributing to a background which includes many other exposures.

In bioassays we usually test the effect of a single chemical in isolation, but in human exposures, i.e., "realistically," a vast number of carcinogens interact in space and time, and these complex exposures begin with the germ cells, continue through embryonal and fetal development, and extend throughout the entire lifetime of each one of us.

The important role of animal bioassays is that of demonstrating qualitatively the property of a given chemical to induce neoplasms in a mammalian test species. Our state of knowledge strongly indicates that this activity is potentially analogous in the human species, and that therefore materials found to be carcinogenic in animals ought to be handled as if they were known to cause cancer in humans. The basis for evaluations of environmental carcinogens recently was reviewed and extensively discussed (Saffiotti, 1977 a, b,^{7,8,9} 1978).

The basis of this correlation recently has been extended well beyond a morphologic similarity between animal models

and human pathology. The value of animal models for cancer induction is apparent at several levels. They are the necessary tools for the study of the mechanisms of carcinogenesis in the specific target tissues. They lead to the experimental identification of early markers of neoplastic transformation which can become useful tools for early diagnosis. They are the experimental systems used in the identification of pharmacologic inhibitors of tumor induction or development, which now are opening the way toward the pharmacoprophylaxis of certain types of cancers in high-risk individuals. But also the experimental models for cancer induction in animals are the basis for a closer comparative analysis of the response to chemical carcinogens in animals and in humans. We need to know whether we can rely on animal models to predict the response of human tissues and organs to chemical carcinogens, and the predictive value of the animal systems derives from critical determinations of close comparability with the human counterpart.

The target organ site for a carcinogen may vary from species to species and even under different conditions of exposure; therefore, we should not expect the carcinogenic effects in people to be at the same site observed in animal tests.

PROGRESS IN CELL BIOLOGY

In addition to studies of the response of the whole organism to carcinogens, progress in cell biology has made it possible to examine the response at finer levels of biological organization, i.e., at the tissue, cellular, and molecular levels. These levels of experimental analysis have revealed a great deal about the handling of carcinogens in target tissues, the metabolic activation of exogenous chemicals into reactive molecules capable of binding to target cell macromolecules, and even the precise chemical structure of the products formed by the binding of several carcinogens with specific reactive sites in the nucleotide bases of DNA. Radioimmunoassays have been developed for these DNA-carcinogen adducts and they could be most useful in localizing and quantifying the specific damage produced by carcinogens.

Methods for studying the effects of carcinogens directly on tissues and cells include those based on organ and cell cultures. They have made it possible to demonstrate that carcinogens can induce a neoplastic transformation of cells in culture and that the cells that thus are transformed chemically grow as neoplastic cells when inoculated into compatible host animals.

A number of reproducible model systems for the neoplastic transformation of mammalian cells in culture have been developed and are becoming a new source of information on the carcinogenicity of chemicals. They represent a short-term methodology for the identification of carcinogens based on the rapid induction of an actual neoplastic state (reviewed in: Saffiotti and Autrup,¹⁰ 1978).

Other short-term tests that have been developed recently include those for the induction of mutations in bacteria, in other lower organisms, and in mammalian cells. Additional short-term tests are those based on chemical reactivity and the induction of DNA damage and repair. The predictive value of short-term tests is presently under study as these tests are validated in relation to test standards and *in vivo* effects. The currently prevalent view is that a battery of such tests constitutes a valid predictor system, with some exceptions, and that positive results from such tests provide useful supporting evidence to long-term *in vivo* tests in

animals.

An important advance in carcinogenesis studies has derived from the development of *in vitro* techniques, and that is their applicability to *human* tissues and cells in culture. Advances of the last few years (to which our laboratory has contributed a major share with the work of C. C. Harris and co-workers) have demonstrated that the effects of carcinogens can be studied directly in human target tissues maintained in culture (Harris,² 1976; Harris, *et al.*,³ 1976; Harris, Saffiotti and Trump,⁴ 1978; Saffiotti and Harris,¹¹ 1978). Major target epithelial tissues for human cancer have been studied, such as bronchus, colon, and pancreatic duct. Normal tissues are obtained at surgery or at "immediate autopsy" and rapidly placed in culture media. The methods that have been developed have resulted in the excellent preservation of these tissues both morphologically and functionally for periods of weeks or even months.

These explants of human tissues have become, therefore, experimental biological systems and have made it possible to undertake the study of carcinogenesis in humans by the experimental method.

The results so far can be summarized in two parts: From the qualitative point of view, the pathways of carcinogen activation, localization, binding, and direct effects on target tissues are extremely similar in animal and human tissues. This close parallelism of animal and human response, extending from the tissue to the cellular and molecular level, provides a strong additional basis for the validity of animal models as predictors of the human response to carcinogens.

From the quantitative point of view, on the other hand, the major finding has been that of a marked interindividual variation among different patients in the level of their tissue response for each measurable parameter of response to carcinogens. This interindividual variation of tissue response is of the order of 1:100, as determined in groups of about 100 adult patients.

But let us return to the question: "What are the threats to your patients?" The experimental approach which I have tried very briefly to summarize offers much more than a mere set of routine tests. It gives us an insight into the pathways that environmental chemicals find in our body in order to reach target organs and cells in which they trigger neoplastic changes.

As the rapid progress of the experimental study of carcinogenesis unfolds, we expect that it will become possible also to identify on a solid basis of evidence those conditions under which certain carcinogens are not likely to be effective in certain particular individual patients or groups of patients and those conditions under which certain people are placed at a particularly high risk. We expect also to learn how to intervene pharmacologically to inhibit in some cases the process of carcinogenesis in high-risk people.

But these are so far only glimpses into a somewhat distant future. At the present time it is our responsibility to prevent as many cases of cancer as we can by combining our efforts at different levels. A closer integration of experimental, clinical, and epidemiological work can contribute greatly to focusing on realistic and attainable goals of cancer prevention.

ROLE OF THE PRACTICING PHYSICIAN

The contribution of the practicing physician can be important at several different levels. One of the sources of carcinogenic threats to your patients is from voluntary exposures to carcinogens which are part of social habits:

tobacco smoke, alcohol, and certain dietary patterns. A number of consumer products and foods which are found to be contaminated by carcinogens, identified through the experimental method, easily can be abandoned for safer alternative products. The physician can go a long way in educating his patients not to dismiss the threat of newly recognized carcinogens with some stale clichés of a callous manufacturer's propaganda.

Another source of carcinogens that can be controlled effectively is that of occupational exposures. Here again the informed physician will endeavor to consider the occupational history of his patients, extending well beyond the list of carcinogens already demonstrated by epidemiologic evidence, paying special attention to all those carcinogens that are known from good experimental studies and also considering chemical analogs and related materials and processes. The alert physician will identify patterns of early response to suspect carcinogens, especially if examining a large group of similarly exposed workers.

Up-to-date sources of information on the chemical identity, production, occurrence, usage, and biological activity of environmental carcinogens are given in the IARC Monographs on the Evaluation of the Carcinogenic Risk of Chemicals to Man, (IARC, 1972-78) of which 16 volumes covering 368 compounds have been published so far (reviewed in: Tomatis *et al.*, 1978).¹⁴

A particular function of the physician is in the public role of health advisor to his patients, to his community, and to society at large, including its elected political representatives and the local, state, and federal governments.

CONCLUSION

An increased awareness of the modern methods and findings offered by experimental studies in cancer causation and prevention can give to the physicians the solid basis they need to counsel their patients wisely, to protect their health more effectively, and to share in the commitment of our society to reduce to a minimum the unbearable toll we now pay to "man-made" cancer.

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Industrial Methods of Detecting Environmental Cancer Hazards*

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Major aspects of the function, operation, and industrywide role of a modern industrial toxicology laboratory are reviewed with particular reference to detection of cancer hazards.

We in industry welcome the opportunity to participate in this very important conference. Industrial methods of detecting the hazards from environmental cancer are really a synthesis of the experimental^a and epidemiologic^b methods that just have been described. This synthesis is, of course, directed particularly toward industrial toxicology and industrial medicine. At Haskell Laboratory, we strive to do research and provide technical skills that will protect the worker, the consumer, and the environment from all toxic hazards including cancer of occupational origin.

LABORATORY TESTS AND SERVICES

The stepwise progression of animal and other laboratory tests to evaluate toxicologic hazard routinely leads to tests that help define carcinogenic potential. At the research and development level we handle all materials as potentially toxic. Our first step is to provide information by collecting available data on the known toxic characteristics of the test compound. Second, we supplement the published data by our own testing as necessary so that we can assess short-term toxicity. At this level our current battery of routine tests includes oral, skin and eye, inhalation, aquatic, and screening for carcinogenic potential by *in vitro* mutagenicity tests. Many commercially interesting compounds are eliminated by this short-term battery. Materials or processes that warrant semiworks or plant production are then evaluated for potential chronic toxicity testing by the oral or inhalation route. Chronic tests may extend to lifetime

exposure of animals, to simulate the exposure that would occur in a working lifetime of humans—approximately 40 years. At the present time, for example, we have ten two-year oral tests and four two-year inhalation tests under way (in house). Special tests include teratogenicity and reproduction studies, metabolism studies, and cardiac sensitization. In aquatic toxicology, which we now regard as routine, acute static bioassay and dynamic studies may be supplemented with chronic studies to provide information on reproduction and growth.

Chronic tests in multiple species are both costly and time-consuming. Increasingly, scientists are searching for short-term screening tests to help define the carcinogenic potential of chemicals. For about three years, Haskell has employed the Ames bacterial mutagen test using several strains of *Salmonella typhimurium*.¹ The Ames test has proved useful because about 90 percent of the known human or animal carcinogens that have been subjected to it have proved to be mutagenic.²⁻⁵ Not every chemical which is mutagenic to bacteria in the Ames test will cause cancer, but the possibility is strong enough that a "positive" Ames test becomes a warning flag, a signal that further testing will be needed.

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^aSaffiotti, p. 752 —^bHoover, p. 746.

Additional short-term screening tests would be very helpful to improve predictability. One promising assay measures mutagenic activity in cultured mammalian cells—specifically, Chinese Hamster Ovary (CHO) cells.⁶ Other screens involve the use of strains of mouse cells and hamster cells that are especially sensitive to chemical carcinogens and actually become tumorigenic^{7,8} rather than simply showing mutations. Judging from our own data and a recent comparative evaluation sponsored by Imperial Chemical Industries Limited,² it appears that it may be desirable to use the Ames test plus one or more other short-term tests, rather than depending on any one single test.

Haskell Laboratory also provides field service. We bridge the gap between test chamber and the workplace through a group of experienced industrial hygienists and physicians who assist our plants in setting up the necessary health controls. These people provide on-site consultation on toxicity problems. Their recommendations may be translated into equipment to reduce exposure by a special group of design engineers in our engineering department.

ESSENTIALS OF AN INDUSTRIAL TOXICOLOGY LABORATORY

To place what I just have said into perspective, optimum operation of a modern, industrial toxicology laboratory requires, as a basic essential, *broad capability*. Today, as the biochemical orientation of toxicology increases, as analytic measurements become more sophisticated, the demand grows for a greater number and diversity of tests.

A second essential for an industrial toxicology laboratory is *quality*—the ability to perform and conduct scientific research of the highest caliber. Quality assurance programs are now a part of American professional life. At Haskell Laboratory, we have our own internal Quality Assurance Committee to help ensure the accuracy of test results and interpretations. Individual company efforts to assure the validity of tests are aided by good laboratory practice guidelines issued by the Pharmaceutical Manufacturers Association⁹ and the accreditation program of the American Industrial Hygiene Association.¹⁰ As many of you know, corporate laboratories proved to be the top performers in the Food and Drug Administration's pilot monitoring and inspection program conducted last year at 42 laboratories around the country.¹¹

The third essential is a deep-seated conviction in the absolute necessity of *information sharing*. An important resource of any laboratory is the library of pooled information. Sometimes a number of tests can be eliminated because the scientific literature already may contain all or most of the knowledge needed to determine how a chemical should be handled. Haskell Laboratory is linked directly with such computerized information banks as "Toxline," "Chemcon," and "Medline." Over and beyond enlightened self-interest, however, we believe a toxicology research laboratory has a moral responsibility to *share* information. The key consideration here is whether new toxicologic data would lead anyone outside our company to act differently on a rational basis to enhance safety. If such is the case, the information should be released promptly, irrespective of market considerations. A case in point is hexamethylphosphoramide (HMPA), manufactured in one of our New Jersey plants, which Haskell determined in the fall of 1975 could cause cancer in rats. The phosphorus-based solvent was known to be toxic and a chemosterilant, but no evidence of its cancer-causing effect on animals previously had been recorded.

Du Pont notified employees, government agencies, and other manufacturers, and also took immediate steps to alert the scientific community by simultaneous letters to *Science*,¹² *Chemical and Engineering News*,¹³ and *Nature*.¹⁴

Effective communication is a two-way street. Earlier this year, NIOSH informed us that "Moca," a curing agent also manufactured at a New Jersey plant, was a carcinogen in animal tests conducted at Hazleton Laboratories. We appreciate this confirmation from NIOSH. We had treated this material as a suspected experimental carcinogen for about ten years,¹⁵ based on various reports including our own laboratory tests with rats and dogs. As a matter of fact, "Moca" was one of the original 14 carcinogens regulated by OSHA.

The fourth and last essential of a corporate toxicological laboratory that I would like to discuss is its need for being *well integrated* into the company's overall employee health program. The attack on chronic occupational health hazards must be many-pronged. In addition to sophisticated toxicological research effort to identify subtle health hazards and help determine safe exposure limits, there must be a broad effort to collect and analyze epidemiologic data on illness and cause of death among employees. This may reveal areas of subtle risk that need further investigation. Our Medical Division now routinely compiles such data on current and retired employees. A cancer registry of all active employees who developed the disease has been maintained since 1956. The purpose is to have sufficient information for comparing employees' cancer experience with other population groups to determine whether any types of cancer may be related to occupational exposure.

PLANT STUDIES

The effectiveness of this type of research is indicated by preliminary results of a study completed last year among employees at our Camden, South Carolina, plant who initially were exposed to acrylonitrile 20 or more years ago and who showed a higher than expected number of cases of cancer.¹⁶ This experience emphasizes the importance of information-sharing since it was animal test data previously reported by the Manufacturing Chemists Association that caused us to accelerate our epidemiologic study already in progress in Camden. It also illustrates one of the major problems involved in cancer detection, namely, the long latency period before the disease appears. The Camden site was the only plant with an adequate cohort where our employees could have been exposed to acrylonitrile for at least 20 years—a period generally accepted as a sufficiently long latency time to look for the induction of cancer in humans.

DuPont also has participated in industrywide epidemiologic fact-finding. As a member of the Dry Color Manufacturers' Association, duPont participated in a study¹⁷ carried out by Equitable Environmental Health, Inc., in three plants—two manufactured lead chromate pigments and the third manufactured lead chromate and zinc chromate pigments. The incidence of lung cancer among workers was slightly higher than would have been expected in all three plants, but the numbers of cases were too few to apply the usual tests for statistical significance. However, it was concluded that there was an excess. The duPont plant at Newark, New Jersey, which manufactured both pigments, also showed an excess in cases of stomach cancer. These findings currently are being investigated.

DUPONT'S GUIDELINES FOR CARCINOGENS

Having the data in hand does not in itself insure employee health. Adequate controls and safeguards should be applied in a uniform manner across the corporate body. Three years ago, to implement the data gathering and fact finding, duPont's Environmental Quality Committee established guidelines for our company's classification of chemical carcinogens. When all available evidence on a chemical has been accumulated and evaluated, the decision may be made to describe it as causing cancer in human beings; as causing cancer in animals; or as a suspected carcinogen in animals or humans. Classification automatically triggers a course of action. Depending on the circumstances, a variety of groups—employees, customers, appropriate government agencies, the news media—may be notified of the actions taken.

Integration also must be external, as well as internal. Haskell Laboratory personnel are in frequent contact with commercial, academic, and governmental research establishments. I have mentioned that we participate in joint studies with other companies or industrial trade associations. Another important association is with the Chemical Industry Institute of Toxicology, which was created in 1974 and currently is supported by 28 companies to undertake toxicity studies and nonproprietary research on widely used chemicals.

APPROACH TO REGULATORY POLICY

Several months ago, Representative James Martin of North Carolina proposed¹⁸ a regulatory policy for food additives which, to my way of thinking, is sensible. In brief, his policy is derived by asking four simple questions about a substance under consideration:

- Is it carcinogenic?
- If so, how potent is it?
- What best estimate does that afford as to the public risk, considering the manner and extent to which we actually are exposed to it?
- What regulatory option is most appropriate to this risk in comparison with other ordinarily acceptable risks, and the benefits of the substance?

While Congressman Martin's policy—coupled with the information-gathering, industrial research activity I have outlined—is directed at food additives, we feel that this approach could be applied in other areas such as the workplace. It also could be helpful in attacking many other factors involved in the environmental cancer hazard, such as air pollution, diet, and cigarette smoking. In some cases various factors appear interrelated, as has already been established for exposure to asbestos and cigarette smoking.

OVERVIEW

This brief address can only highlight the basic concept of various industrial programs used to appraise carcinogenic potential. In a few words, the situation is complex, and clearly we do not have all the answers. But the momentum is here and the effort is being applied. Industry today does have a deep concern and is increasingly aware of its responsibility

to eliminate or minimize hazards in areas under its control. We look forward to working with you and others toward a significant reduction of the overall environmental cancer hazard.

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Social Responsibilities in Cancer Detection-- What State Government Is and Should Be Doing

PETER W. PREUSS, Ph.D., Trenton*

Recent evidence points up the importance of broadly defined environmental factors in cancer incidence. The State of New Jersey is working toward identification and reduction of some of these factors. Three examples of the Program on Environmental Cancer and Toxic Substances, a part of the state's cancer "prevention" program, are a statewide groundwater study surveying for 50 chemicals, environmental analysis of factors that may be related to the clusters of leukemia and Hodgkin's disease in Rutherford, and a statistical study of cancer mortality in the state and surrounding counties.

This paper concerns the role of state agencies in dealing with environmentally related cancer hazards.

In another paper in this issue (p.743) Stewart Pollock, the Counsel to Governor Byrne discussed some of the statistics that have caused us much concern in New Jersey, and have gained for us the unfortunate nickname "Cancer Alley." The question that we need to ask is whether the mere existence of such statistics provides sufficient reason for state government to establish an extensive, intensive, and comprehensive cancer program. It certainly can be argued (and has been argued) that state agencies should play no role at all, or at least a very minor role in this arena.

To begin to answer this question, we first must look at the existing spectrum of efforts against cancer. Certainly, support and implementation of basic research is beyond the capabilities of most states. We have neither the extensive funding nor the laboratory research facilities that would permit either of these. A look at the billion dollar budget and excellent physical facilities of the National Cancer Institute confirms that fact. We cannot add significantly to the activities of the National Institute for Occupational Safety and Health, the National Institute of Environmental Health Sciences, the Environmental Protection Agency, and others, in supporting research to determine the effects of environmental factors on human health.

At the other end of the spectrum, there is also the well-defined role of individuals and groups that also is outside the framework of state efforts. This is the role of "health care provider"—the important role that physicians and their

professional associates fill. Obviously, the state cannot hope to have this kind of hands-on involvement in the treatment of cancer.

IS THERE A STATE ROLE?

In between these scientific and medical extremes is an area that has been disregarded all too often by both the research scientist and the physician. This middle ground is defined in part by the recognition of the importance of environmental factors in cancer mortality and morbidity. In the past this area has appeared to be insignificant and therefore was disregarded with some justification. Recent evidence has shown that broadly defined environmental factors are a very important determinant in the incidence of cancer, and it follows that the identification of these factors can be significant in the prevention of cancer. Prevention, in this case, would be reduction or elimination of the environmental factors generally believed to cause a majority of cancers. With this goal, this vision of what is possible, we have made the decision that a state effort is worthwhile and necessary. And, not only have we made that decision, but we have gone ahead to design and implement that program with enthusiasm.

*Presented at the Fourth Annual Governor's Conference on Environmentally Related Cancer Hazards in New Jersey, 212th Annual Meeting, MSNJ, May 6, 1978, Atlantic City. Dr. Preuss is Special Assistant to the Commissioner, Department of Environmental Protection, assigned to the Program on Environmental Cancer and Toxic Substances.

Perhaps the projects that were listed this morning appeared to be discrete, separate, and disassociated elements. However, the strong theme of cancer prevention which defines the area of the State's activities also unifies these projects.

Detailed evidence described the importance of environmental factors in the causation of this disease. But there is much more evidence that strengthens and supports this hypothesis. The evidence has come from research projects varying from detailed prospective epidemiological studies to retrospective statistical correlations; from a study of cancer mortality rates in different countries of the world to cancer mortality rates of peoples migrating around the world; from exposure of workers in uncontrolled industrial environments to exposures of test animals in strictly controlled laboratory environments. All have tended to point to a distinct causal relationship between exogenous environmental factors and cancer.

This evidence forms a large part of the foundation for the State's program. Combined with that is the real possibility of synergistic relationships between various factors. It is generally accepted that the risk of cancer from exposure to several factors is much greater than the sum of the individual risks. These factors include personal habits such as diet, drinking, and smoking, as well as environmental factors. These factors seem to work together, amplifying the risk of cancer for an individual. These, then, are the hypotheses that may aid us in our attempts to understand the high cancer mortality rates in New Jersey. The environmental risk concept leads us to a very clear understanding that we cannot resolve the problem by placing responsibility on one sector of the economy or on one environmental medium. Rather, it suggests that we must attempt to define the multiple series of exposures that may be involved, and then to understand relationships among these factors, and finally to reduce or eliminate those factors of greatest importance.

SOME CURRENT STATE PROGRAMS

The state programs and projects that already have been discussed, as well as many others that are now underway, generally orient toward the first and second points above: identification of exposures and the understanding of the relationships involved. For clarification, I have selected a number of examples to discuss in more detail. These examples should not leave you with the impression, however, that they are the only programs under way. There are many others that are being conducted by our office and other state agencies. Because I am much more familiar with programs within the Department of Environmental Protection (DEP), I have chosen the following:

1. A study of carcinogens in groundwater
2. An attempt to understand the clusters of childhood leukemia and Hodgkin's disease in Rutherford
3. An analysis of the spatial distribution of cancer mortality and of factors associated with increased and reduced risk of cancer mortality in the New Jersey-Connecticut-New York-Philadelphia metropolitan region.

CARCINOGENS AND TOXIC SUBSTANCES IN GROUNDWATER

The groundwater study is part of a larger effort to analyze the waters of the state for a variety of trace contaminants. The latter is part of a much larger program designed to survey trace substance levels in air, water, soil, fish and other marine life, as well as other animals higher in the food chain.

There is a very straightforward reason why our monitoring programs are so extensive: this kind and amount of data have never been gathered before. We started two years ago from a point of almost total ignorance—not knowing what carcinogens were present in the environment, and in what concentrations. We decided then to remedy the situation as quickly as possible.

The groundwater study, which is about two-thirds completed, examines groundwater supplies in all parts of the state for fifty selected toxic chemicals, a number of which are known or suspected carcinogens. The fifty chemicals for which the water is being tested are divided into three groups:

1. Organic chemicals, particularly the low-molecular weight, halogenated hydrocarbons such as chloroform, trichloroethylene, and vinyl chloride,
2. Pesticides, including those pesticides which once were used extensively in this state but which now are banned (as well as substances which are not in fact pesticides, such as PCBs^a, but which have similar chemical and biological properties),
3. Heavy metals, such as chromium and cadmium.

The results from the first 250 wells that were tested recently were published in an interim report^b together with a description of three trends that already clearly are discernible. The data we have gathered, so far, indicate that:

1. All of the wells tested contained trace levels of some of the chemicals under investigation,
2. The presence of low levels of pesticides was most prevalent in the agricultural areas of the state, and
3. The majority of the wells which were found to be contaminated by organic chemicals were located in densely populated and heavily industrialized areas.

Our major problem since the inception of this project is that so little is understood about the long-term human health effects of exposure to low levels of these substances in the water and general environment. In the absence of federal regulations and standards the Department of Environmental Protection and the Department of Health must develop guidelines by which we can judge which levels of contaminants demand action by the State. We have notified all well owners of the results of the study, and plan to do extensive follow-up work on the wells with significantly high values, in accordance with the study design.

RUTHERFORD

The second example, the cases of leukemia and Hodgkin's disease in Rutherford, is, in a sense, representative of the many localized but serious issues with which we have had to deal in the past six months. These problems have been as varied as a compendium of toxic substances, and have taken the form of accidents, spills, industrial emissions, and many others. Specific situations have ranged from PCBs^a in New York Bay, to lead poisoning in children in Elizabeth, to the explosion and fire of a chemical waste facility in Logan Township, to PBBs^c in Sayreville and Bayonne, to clusters of leukemia and Hodgkin's disease in Rutherford.

^apolychlorinated biphenyl

^bPreliminary Findings¹ of the State Groundwater Monitoring Project. Over 500 groundwater samples were taken and analyzed by the Department of Environmental Science, Cook College, Rutgers University. The 50 chemicals for which the water was tested include pesticides, organics, and metals. The federal safety standards for metals and pesticides in drinking water were used in this study, and a proposed 100-ppb standard was used for the organics group called trihalomethanes.

^cpolybrominated biphenyls

In Rutherford, we were faced with two immediate questions:

1. Did the number and location of the cases really represent an unusual cluster, or were they a statistical quirk?
2. If the cluster of cases was real, was there some relationship or pattern associated with them that could help to explain why they occurred?

These questions certainly are not unusual ones to ask in a situation like this. The difference here is the breadth of professional expertise that has been brought to bear, and the extent to which environmental factors are being investigated and analyzed.

Epidemiologists from the Department of Health have interviewed the families of the leukemia patients involved, looking for common histories, habits, or any other clues. The interview questionnaires were particularly difficult to prepare, because only a very few factors have been associated with leukemia. The Department of Health mobilized quickly and with great professional competence in response to this emotionally charged situation.

Our first action was to prepare a comprehensive industrial/non-industrial source profile and an environmental profile of the Rutherford area to see what already was known about the area. Second, we prepared monitoring plans to be used in case the epidemiological survey gave us specific clues. Finally, we went to Rutherford and took samples at the school and in the area around it to assess the degree to which the different environmental media might contain carcinogenic agents. This step, we realized, was fraught with uncertainties; we really did not know which specific substances or factor we should be looking for; we had no way of knowing whether the factors present when we sampled were the same ones present years ago; and we were not even sure that we would be able to recognize a factor of importance, were we to come across it.

In many ways, what we have been doing is the environmental parallel to the classic epidemiological investigation; the painstaking sifting through masses of information to determine whether several isolated pieces within the mass are related and can explain the phenomenon being investigated.

Frankly, I don't know at this point whether or not this approach will be successful. I only can hope it will. But whether it succeeds in this case or not, I am convinced that we are developing a methodology which, with some further refinement, will become an important tool in our cancer program.

CANCER PATTERNS

The final topic that I want to discuss concerns a Rutgers University study that we have been sponsoring to look at the mathematical associations between the geography of cancer mortality and the geography of factors thought to lead to elevated or reduced cancer risk. The study, which has been under the direction of Professor Michael Greenberg, includes all of New Jersey and adjacent portions of New York, Connecticut, Pennsylvania, and Delaware. The area is composed of 49 counties, and has a population of about 25 million people.

We used the National Cancer Institute cancer mortality data for 1950-1969 and mortality data from the National Center for Health Statistics for 1969-1972 for this study. These data were age, sex, and race adjusted. To relate the cancer mortality data to environmental and other factors, we drew on whatever reasonable information was available, including U.S. Census of Population and Manufacturing

reports, annual reports by the Federal Power Commission, and records of the New Jersey Departments of Environmental Protection and Transportation, and their counterparts in neighboring states.

As you already have heard several times, the cancer mortality rates for the region and for New Jersey are nearly always higher than the national average. Therefore, even before doing the statistical correlation studies, we mapped the cancer rates and analyzed the rates themselves to see what patterns and what relationships among different types of cancer would emerge. The full report of this study is undergoing peer review at the moment, so that I am unable to share all of the results with you. These will be published shortly; however, I do want to discuss a few of the geographical patterns that emerged.

Using factor analysis and other statistical techniques, we distinguished five groups of counties by the cancer mortality patterns manifested by their white residents:

1. Corridor group which consists of counties located along the region's urbanized corridor. They exhibit high rates of cancer at all sites—lung and associated sites, stomach, female breast, rectum, and intestine. The counties that most strongly manifest these mortality rates are (from north to south) Putnam, Nassau, the boroughs of New York City, Hudson, Essex, Middlesex, Monmouth and Philadelphia. These counties have cancer mortality rates about 20 percent higher than the national average.
2. Counties located in the southwest and northern portion of the region generally have low rates of all cancer categories. None of these are in New Jersey. These "low" counties have rates that are about the same as those of the United States as a whole.
3. There are counties located in the western portion of the region that exhibit high mortality rates for male leukemia, male stomach cancer, female breast cancer and low mortality rates for male intestine cancer and male and female kidney cancer. The best examples of the western factor are Sussex, Warren and Hunterdon counties in New Jersey, and Pike county in Pennsylvania.
4. Counties located in southern New Jersey and adjacent Pennsylvania and Delaware manifest relatively high mortality rates for female bladder and female intestinal cancer, and low mortality rates for female pancreas and rectal cancer and male liver cancer.
5. The fifth group includes about 20 percent of all the counties studied. These did not closely identify with the four multi-disease groups I have just described. Some, such as Salem county, had such high rates of a single cause of mortality (e.g., white male bladder cancer) that they are unique. Others had moderate but not strong identification with any cancer group.

To summarize all of this is difficult, but the preliminary study clearly indicated that the region has a distinct geographical distribution of cancer mortality. This result was very encouraging because it suggested that these patterns possibly could be dissected and isolated. Further study might identify the environmental factors that formed them. A much fuller description of this methodology and the results of the analysis and correlation of individual factors will be available when the complete report is published.

CONCLUSION

Three examples of DEP projects illustrate some of our general objectives:
—to identify the extent to which people in New Jersey are

exposed to carcinogenic agents,

- to correlate the exposure of people to carcinogenic agents and other environmental factors with cancer morbidity and mortality, and
- to use the knowledge gained to understand specific disease cluster etiologies and patterns, to reduce or eliminate exposure to carcinogenic agents where warranted, and thereby to move closer to our goal of prevention.

These projects also complement a whole series of programs and studies that are being carried out by other State agencies, most notably in the Department of Health and the Department of Labor and Industry. Some of these, such as

the Department of Health's cancer registry mandated by the Legislature last year and the bladder-cancer study are crucial to our further understanding of cancer rates in New Jersey. The Office of Occupational Health and Safety Consultation Services, run by the Department of Labor and Industry, was designed to help industries voluntarily reduce the exposure of workers to hazardous substances and conditions.

Nevertheless, the program is not complete. A state program cannot exist through State agencies alone. We have to reach out to those affected, and to those with the expertise to help deal with this problem to define more clearly what directions we should take.

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The Social Responsibility in Cancer Detection: The National Scene*

ANDREW MAGUIRE, Ph.D., Paramus

A United States Congressman discusses what government is doing and the future federal plans in connection with the detection and prevention of cancer.

As a New Jersey congressman sitting on the Health and Environment and on the Investigations Subcommittees, I have an unique opportunity to participate both in investigations and in legislation on public health matters. One of our particular areas of concern relates to our nation's — and our state's — growing cancer problem.

In 1975, the National Cancer Institute (NCI) identified New Jersey as the nation's number one state in terms of cancer incidence among white males. In fact, the majority of our 21 counties rank within the top 10 percent in the nation in mortality and incidence of specific cancers according to the 1975 Cancer Atlas.

Most experts believe it is no mere coincidence that New Jersey is one of the nation's most industrialized states and one where the chemical industry is dominant. Likewise, it is no mere coincidence that we have one of the nation's highest traffic densities. These two environmental elements undoubtedly affect our state's cancer rate.

Recently, New Jersey has begun some very ambitious new efforts. For example, the State Department of Health now is developing a registry of all persons in whom tumors develop. Few other states have such registries. Meanwhile, the Department of Environmental Protection (DEP) has begun an essential counterpart of the tumor registry which pinpoints the location of the manufacture and discharge of a wide range of toxic and carcinogenic chemicals.

The DEP also is developing the capability to monitor all

sorts of contaminants in the air, water, and soil. This newly developing capability for sophisticated monitoring of the environment and analysis of specific health data may pay off, not only by helping us to lower exposure to toxic and carcinogenic substances in the state, but also by making New Jersey a test area in which to conduct pioneering work in epidemiology. The long-term result should be a gradual reduction in cancer incidence in the state.

EPIDEMIOLOGY OF CANCER

Some of the pioneering work in epidemiology, linking asbestos to lung cancer and other sites was done right here in Paterson, New Jersey by Dr. Irving J. Selikoff of the New York Mount Sinai Hospital. As a result of the asbestos studies, the Department of Health, Education, and Welfare now has adopted the kind of public information effort which is a crucial first step toward educating the public on the problems of occupational and environmental carcinogens. Secretary Califano recently announced an effort to alert the nation's 400,000 doctors to the high risk of cancer facing the 8.5 million individuals who worked in the asbestos industry. Califano advised physicians to seek occupational histories of their patients to determine who among them may have worked in Navy shipyards during World War II. This

*Presented at the Fourth Annual Governor's Conference on Environmentally Related Cancer Hazards, May 6, Atlantic City. The Honorable Andrew Maguire is Congressman from the Seventh District, New Jersey.

may be a particular problem here in New Jersey where major Navy facilities were located in Hoboken and Kearny. If the majority of these workers can be reached through their doctors, their trade unions, and through a nationwide public information program, there will be more of a chance, through early diagnosis and treatment, to save some lives that otherwise would be lost. The asbestos alert is the most appropriate response to a situation where an epidemiological study has identified a population at risk due to occupational exposure to a carcinogen.

This outreach approach might be used more widely in other public health problems. It would, for example, be possible to provide appropriate warnings to workers found to be exposed to similar dangers in the chemical industry. This becomes increasingly important because our cancer rate is rising. The age-adjusted death rate for cancer rose from 112 cancer deaths per 100,000 in 1930, to 120 in 1940, 125 in 1950, and 130 in 1968. Much of that, of course, was due to the increase of lung cancer.

It is to the credit of the medical profession that, despite the rising cancer rate, we have seen a corresponding increase in survival rates for some forms of cancer due to surgical procedures, radiation, and chemotherapy. Improved statistics are also the result of the increased performance of Pap smears and rectal examinations on a regular basis, as well as education of females to conduct regular self-examinations of the breasts.

These advances are laudable. Today, we know much about the cancer process, about carcinogens, populations at risk, and how to test compounds for carcinogenicity. And yet, as far as understanding the fundamentals of the actual cellular processes and initiators of cancer we have, according to such leading researchers as Nobel laureate James Watson, a long, long, way to go.

FUNDING CANCER RESEARCH

Only through increased funding of basic research into cellular processes can we learn how to intervene in the cellular process to halt or reverse the spread of cancer indefinitely. This fundamental research is essential to a successful national cancer control program.

PREVENTION

In the meantime, as that work proceeds, we must focus our national cancer program on prevention and the earliest possible diagnosis and treatment. These two efforts go hand in hand. Both require much effort to be placed on identifying at-risk populations, and tough regulatory action to limit further risk to the extent that it is feasible.

In the last several decades, the nation has become more concerned about the environment. As a result of this heightened consciousness of environmental issues, important legislation has been passed to protect the public health. This includes the environmental impact statements under the National Environment Protection Act (NEPA), the Water Pollution Control Act, the Food and Drug Act, the Clean Air Act, and the Toxic Substances Control Act.

In the pursuit of a better life, we have introduced thousands of man-made chemical products in our environment including plastics, pesticides, drugs, food preservatives and colors, and synthetic clothing—and thousands more new chemicals enter the marketplace each year. Unfortunately, there has been no regular mechanism to test these chemicals for toxicity and carcinogenicity before release. In the past, with the exception of drugs, which must be proved "safe and

effective," there has been no pre-screening or testing requirement for either government or industry.

The result of this failure to pre-test chemicals before we begin circulating them has been one unfortunate crisis after another. The litany includes such carcinogenic substances as PBB's,^a which entered the food chain in Michigan; pesticides such as chlorodane, heptachlor, and kepone, which have been found in fish; TRIS which was being put in children's sleepware; nitrosamines in cosmetics; and asbestos, which was found in samples of children's talcum powder.

One of the more significant pieces of legislation I have had the opportunity to work on in Congress was the Toxic Substances Control. The Toxic Substances Control Act, or TOSCA, is the beginning of the process of protecting the public from dangerous chemicals not covered by other legislation. It also will provide protection from the flood of new compounds to which the public is exposed each year. Under the Act, chemical manufacturers must notify the Environmental Protection Agency (EPA) three months before beginning the production and marketing of a new chemical, or before marketing an existing chemical for a significant new use. If the EPA Administrator decides that the new chemical may present risks to human health or the environment, or that too little is known properly to evaluate its effects, the Administrator can limit production or use of the chemical either indefinitely or until the substance has been tested adequately by the producing firm.

In working on regulatory legislation, I always take the position that whenever we err on these complicated questions of regulation we should err on the side of caution and protect the public from risks that even may be unforeseen. We make a lot of mistakes. For example, acting from the defensible motive of protecting women from breast cancer, for many years we conducted a very vigorous campaign of x-ray mammography. Since then, serious questions have been raised about the desirability of routinely exposing women to a known carcinogen in order to detect the possibility of existing tumors.

Unfortunately, in such cases legislators often must act before all the data are available and before we know the full magnitude of a given problem. That is what makes basic and applied research so important. Today we need more data faster than ever before. But, we always must *act* on the basis of the data we have in hand. Unfortunately, as policymakers, legislators cannot require the same standard of evidence that scientists do. The risks the policymaker faces are so much greater. We are not talking about the ability to make absolute assertions. Rather, legislators are trying to protect the public from imminent and serious hazards.

BIOMEDICAL RESEARCH ACT

I want to close by discussing the Biomedical Research Act which just was approved by the full Commerce Committee. I was able successfully to amend the act in Subcommittee to assure that the National Cancer Institute (NCI) pays more attention to prevention. Under my amendment, the Act was modified to say that the National Cancer Institute must conduct an expanded and intensified program of research into cancer prevention. The Institute also would be responsible for coordinating and advising the regulatory agencies on their cancer-control efforts. It is both easier and more cost-effective to prevent cancer than it is to try to cure people once they get the disease. I was pleased to have the

^apolybrominated biphenyls

support of Dr. Arthur Upton, the newly appointed director of the Institute, in my effort.

The Subcommittee also adopted the requirement, so important to our state, that at least five of the 18 members of the National Cancer Advisory Board be specialists in environmental and occupational cancer. It also clarified the responsibility of the National Cancer Institute's Cancer Control Programs to focus on such high-risk populations as our New Jersey shipbuilders. Focusing on high-risk groups is a very effective way of utilizing our limited resources and having an impact.

Finally, the Subcommittee accepted an amendment I offered which makes the National Cancer Institute responsible for issuing an annual report on carcinogens. It would detail the carcinogens to which we are exposed, the number of exposed people, the efficiency of existing regula-

tions, and the NCI's recommendations on how to improve those regulations. These changes in the Institute's role are critical to shifting our focus toward a preventive approach by limiting exposure to carcinogens.

I believe these amendments will make a real difference in how the National Cancer Institute pursues its goal of preventing cancer. With the NCI taking the leading role, there well could be genuine coordination of the anti-cancer effort of the other agencies involved—such as the Center for Disease Control, the Environmental Protection Agency, the Food and Drug Administration, and the Occupational Health and Safety Administration. I believe that these efforts, in combination with the continuing clinical improvements and the critical advances in basic research, provide the chance for major progress in combating this disease that increasingly has plagued our nation and our state.

The Role of the Occupational Health Physician in Cancer Prevention and Early Detection*

JOHN S. TOBIN, M.D., Wayne

The occupational health physician, depending on the policy of his company, has an opportunity to participate in the prevention, detection, and control of cancer among industrial employees.

The physician who serves employed groups may have enhanced opportunities in the prevention and early detection of malignant diseases. Just how great these opportunities may be depends on a number of factors.

OPPORTUNITIES OF OCCUPATIONAL HEALTH PHYSICIANS

First is the nature of the group served. If the group is such that it encounters exposures in the workplace that are covered by governmental standards which include periodic health examinations, the physician naturally sees these people on a more regular basis.

Second is the policy of the organization for which the people work. An employer, be it an industrial firm, a school, a governmental agency, a commercial firm, or a research laboratory, may or may not encourage its employees to have periodic examinations. This encouragement may take several forms. The employer may have such services included in his health insurance program; he may allow the employee time off during working hours to have the examination, or he may pay the cost of the examination directly.

Another factor is the nature of the physician's practice. A physician employed on a full-time or part-time basis by an employer would be in a position to see a given employee on a more frequent basis and often with a greater measure of continuity. If the employee has potential exposure to a carcinogenic substance in his or her work, the physician who is on the staff of the employer has a more direct opportunity to

familiarize himself with the nature of these exposures and their possible effects.

ENVIRONMENT AND CANCER CAUSATION

This latter consideration, while very important, is not the most significant from the standpoint of cancer incidence. Current estimates connect approximately 80 percent of cancer causation with the environment. It must be emphasized, however, that the term "environment" used in this connotation means anything that is not genetic in nature. Included are carcinogenic potentials from factors of everyday living such as smoking, eating, and drinking. It is very difficult to obtain an even reasonably accurate estimate of the role played by work exposure factors in cancer causation but it is probably a minor one. Various opinions have suggested that perhaps 10 percent of malignancies are due to occupational exposures.

These 10 percent of cancer cases still result in approximately 40,000 deaths a year in the United States, about the same number as those dying from diabetes. The opportunity to make inroads on that 40,000 allows the occupational health physician to make a real contribution.

*Presented at the Fourth Annual Governor's Conference on Environmentally Related Cancer Hazards, May 6, 1978, Atlantic City. Dr. Tobin is Associate Corporate Medical Director, American Cyanamid Company, Wayne 07470, and President of the Occupational Medical Association of New Jersey. He may be addressed at American Cyanamid.

COMPANY ORGANIZATION AND HEALTH

Different industrial organizations vary markedly in their organization structure. The exact spot on the chart that the medical director occupies is different in just about every company. As a general rule, though, this is not too important, since most management groups recognize his unique abilities to contribute to employee health conservation and thus his influence is felt far beyond the confines of the little box he occupies on the organization chart.

In my own company, the central medical department, of which I am a part, has a very broad mandate in this area. We have professional supervision of not only the direct employee health programs of the company and its component divisions and subsidiaries, but also of the safety, industrial hygiene, fire prevention, toxicology, and epidemiology functions. We are the advisors to management in all of these areas and also are involved in related fields, such as product labeling, health insurance programs, and consumer safety. We also participate in governmental processes as members of advisory and review committees.

While cancer prevention and early detection are important and the topic of today's symposium, we are interested equally in conserving and improving the health of our employees in relation to other occupational exposures from pinched fingers to central nervous system effects.

We also are acquainted with their life-style—how much and what they eat and drink and whether or not they smoke. We offer our services in the early detection of the so-called natural diseases, such as diabetes, hypertension, heart disease, and arthritis. By early referral to the personal physician and periodic monitoring of the control status we are proud to be able to contribute significantly to length and quality of life of our fellow employees.

CANCER DETECTION

Coming back to today's discussion, we include procedures

for cancer detection in our pre-employment and periodic health examinations. These include a careful history and systemic review by the physician, followed by a thorough physical examination. Chest x-rays, stool examination for occult blood, urinalysis, "pap" smears, proctosigmoidoscopy, and blood analyses also are offered. Our program is on a voluntary basis, with certain exceptions. The examination is offered annually to those forty years of age or older and biennially to those younger. Essentially the same protocol is offered to all employees regardless of status.

Those employees who have occupational exposures attendant with known potential effects have included appropriate added procedures. I am proud to say that the level of participation of our hourly and salaried employees in this voluntary program is very high. At our New Jersey locations, it exceeds 80 percent.

The role of the occupational physician lies in the detection of malignant disease, in referral of the patient to his personal physician for care, in assisting the personal physician in the rehabilitation process, and in proper placement and supervision of the employee on return to work. In almost no instance do we have a part in the treatment process beyond psychological support.

SUMMARY

In summary, we, the physicians who see people in connection with their employment, feel we have a great opportunity to assist our employee populations to prolong and improve their good health, to detect abnormalities at the earliest possible time, to guide them to proper care when necessary, and to assist them to return to useful employment after treatment. We do our best to accomplish this with cancer as well as with other disease states.

Responsibilities of the Practicing Physician in Cancer Detection*

FREDERICK B. COHEN, M.D., Newark

At present early detection is the most effective method of reducing cancer mortality. Mass screening programs for the detection of early cancer have not been proved to be effective. It is the author's contention that a properly constructed and applied cancer screening program by the primary care physician will be successful in reducing cancer mortality in New Jersey.

It is fair to state that the role of the physician throughout the centuries has been fourfold: (1) To relieve human suffering; (2) To improve or restore function; (3) To cure disease; and (4) To prolong life. In the absence of the ability to perform 1, 2, and 3, number 4 is of questionable value.

In order to achieve these goals, the attack on disease by modern physicians has taken the following pathways: (1) Prevention; (2) Early diagnosis; (3) Adequate treatment for cure; (4) Palliative treatment, and (5) Compassionate and effective terminal care.

If we view this order of attack in relationship to the natural history of most disease, we can correlate the ascending numbers with progression from minimal disease to extensively advanced disease. Yet the progress of our successful attack on most of man's afflictions from number 5 to number 1 has been slow. Using infectious diseases as an example, we still are involved in a battle to prevent most microorganism-caused diseases through immunological means or causative agent control. We have developed excellent methods of detection and treatment, but 200 years passed from Leeuwenhoek's discovery of the microscope and 100 years from Pasteur's proof of the germ theory before adequate infectious disease control was perfected. In the field of cancer control, we have not progressed very far up the ladder.

We are attempting to perfect our understanding of patients dying from cancer and making their death more tranquil and

less agonizing by means of better psychologic, theologic, pharmacologic, and institutional methods. We can render palliative care to patients with advanced disease by high-energy radiation, combination chemotherapy, corrective surgery, and powerful analgesics.

Even the treatment of primary cancer is becoming more specific and effective. Today, reasonable choices include surgery, radiation, chemotherapy, hormone therapy, and immunotherapy, which alone or in combination slowly but surely are increasing our "cure rate."

PREVENTION AND EARLY DIAGNOSIS

However, it is in the development of methods of prevention and early diagnosis that the ultimate solution of the cancer problem will come, and, it is here that our progress is least impressive.

Our unimpressive progress is not because of a lack of methods: in diagnosis, we have radiologic, ultrasonic, and biochemical methods of excellent efficiency, while, in prevention, our ability to define and to detect carcinogens in our environment is improving. Our research into such etiologic factors as viruses, environmental carcinogens, and hereditary predispositions is progressing at a rapid pace. It is our failure

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to apply what we now know that is holding us back. Thus, individual citizens (e.g., smokers), industry (e.g., polluters), government, and physicians must be responsible for the application of what we know to the prevention and/or early diagnosis of cancer.

Both organized medicine and the individual physician have roles to play in a successful attack on cancer, which is one of the great causes of suffering of modern man and probably the most important and fascinating biologic problem encountered by inquisitive and caring scientists in the laboratory and in the field.

We must formulate and adopt a uniform operating procedure for the early diagnosis of cancer which can be utilized routinely by individual practitioners. It must be uncomplicated, inexpensive, and applicable to office procedure without special training of the physician. There is no question that the screening techniques which have been applied to large population groups at cancer detection centers can be applied in private practice.

SCREENING BY PRIMARY PHYSICIANS

A properly constructed and applied cancer screening program by primary care physicians has the following advantages over a mass screening program:

- (1) It can be made available to almost all people over a given time since they come in contact with a physician either at home, in the office, or clinic, or their place of employment.
- (2) It can be cost effective since the patient will be receiving primary care as well as cancer screening.
- (3) The patient-physician relationship allows a pursuit in depth of suspicious leads and almost guarantees follow-up care.
- (4) The need for education as to the value of screening can be concentrated on the physician who is usually anxious to learn and more easily indoctrinated. He in turn can educate his patients and colleagues; thus, communication of new ideas can be made quicker, easier, and cheaper.

The disadvantages of such a program are:

- (1) It requires more paper work and complete cooperation of the physician who may resent "commands from above."
- (2) It may involve "unnecessary testing," (a problem which should be addressed and solved by government and other third party payers), and
- (3) It might be misconstrued as an invasion of privacy by the patient or doctor since it would require the regular reporting of data.

COMPREHENSIVE CANCER PROTOCOL

Since the goals of a coordinated cancer control program are the discovery of new cases, and of clues to etiologic factors, the institution of preventive measures, early and more effective treatment, the collection, reporting, and utilization of data are of paramount importance. This best can be performed by government agencies or private agencies under government contract with the complete cooperation of physicians. We should develop a standard history form which should include various risk factors from age, family history and personal habits, to in-depth exploration of dietary,

residential, and occupational exposures. Complete physical examinations including rectal and pelvic examinations must be insisted upon. Facilities for sigmoidoscopy, pap smears, urinalysis, blood counts, and chest x-rays must be readily available and utilized. When they exist, special cancer detecting non-invasive tests utilizing specimens of blood, urine, sputum, or stool collected in the office must be performed. Long-term follow-up using a state-wide tumor registry is essential.

To expedite these goals, the comprehensive cancer center at Newark Beth Israel Medical Center (NBIMC), together with a group of multi-disciplinary professionals from the New Jersey State Departments of Health and Environmental Protection and the Epidemiology-Statistics Division of the University of Pennsylvania Department of Research Medicine, is developing a comprehensive protocol for cancer detection, diagnosis, and pre-treatment evaluation. This protocol, which will be used by occupational physicians, internists, and practitioners of family and community medicine, will seek to identify environmental and occupational carcinogens and to test the validity and utility of a group of non-invasive tests in diagnosing pre-cancerous and cancerous conditions. It will incorporate the history, physical examination, and procedures previously described.

The study probably will be divided into three one-year phases followed by long-term follow-up. During the first year, the proposed protocol and non-invasive tests will be developed and evaluated. The perfected protocol then will be applied to three groups of voluntary subjects from whom informed consent will be obtained:

- (1) Occupational groups
- (2) Groups living in several different environmental areas, and
- (3) Newly admitted cancer patients at the NBIMC.

During the third year, active dissemination of the new protocol will be undertaken. We will try to secure the cooperation of broad-based groups including government, professional societies, health institutions, private societies, foundations, labor and industry, and educational institutions.

Long-term follow-up of patients entered will be necessary in order to correlate our findings with the eventual development of cancer.

SUMMARY

The best way for the medical profession to play a central role in the attack on cancer and for the individual private physician to fulfill his personal commitment to this endeavor should include:

- (1) Finding of cases through early detection and screening
- (2) Identification of risk factors
- (3) Identification of clusters of cases
- (4) Reporting of findings to a tumor registry
- (5) Education of the public
- (6) Active participation in research projects, and
- (7) The discovery of the cause, prevention, and cure of cancer.

Statement on Environmentally Related Cancer Hazards from the State Department of Health

JOANNE E. FINLEY, M.D., Ph.D., Trenton*

There has been much debate lately about whether New Jersey is first, or second, or third in the nation in overall cancer death rates. Isn't it counterproductive, really, to debate such fine points? We know from the fine analytic work of Doctors Mason and McKay of the National Cancer Institute that several of New Jersey's counties do show considerably greater-than-average death rates from cancer at several common sites.

I always have interpreted it to be the responsibility of the public health profession to identify the leading health problems of the people, to set about determinedly but scientifically to use epidemiologic tools to try to shed light on the most probable causes of these problems, and then, together with our clinically sophisticated colleagues, to apply our collective knowledge to the solution of these problems. Thus, the Mason-McKay studies provided all of us, who would like to devote meaningful efforts to the prevention of cancer in our State, with an outstanding challenge.

From the day we received and reviewed the National Cancer Institute's *Atlas*, the New Jersey Department of Health, together with other relevant State agencies, has been pleased to be in the forefront of these preventive efforts. It is exciting work about which you have read in this issue. We believe that, together, we can learn enough about the environments and workplaces and habits of our populations at risk so that we can develop and apply the preventive techniques that will be indicated.

The humane, concerned, and vigorous support of Governor Byrne was signified by his formation of and personal interest in a special Cabinet Committee on Cancer Control in New Jersey.

I personally wish to congratulate Dr. Seymour Charles and the Medical Society of New Jersey for devoting its Annual Meeting Governor's Conference Seminar to the topic of environmentally related cancer agents in New Jersey. The comments of an outstanding panel of speakers can be found in this issue of *The Journal*.

One goal of public health agencies and the practicing physicians of our State is to have healthy, productive citizens. The Conference signified an impressive dedication to that goal through the acquisition of knowledge. Our work for health in New Jersey includes reducing cancer mortality and morbidity and the costly toll that surrounds its impact on families and employers. We still have much to learn, but various cancers are not the totally mysterious scourge we may have thought. If we know and understand agents that certainly appear to be carcinogens and host factors which make some of those persons exposed to these agents most susceptible to cancer, we can design many methods of interrupting the chain of host/agent cancer causation.

*Presented at the Fourth Annual Governor's Conference on Environmentally Related Cancer Hazards, May 6, 1978, Atlantic City. Dr. Finley is New Jersey State Commissioner of Health. She may be addressed at the Department, P.O. 1540, Trenton 08625.

A Statewide Cancer Incidence Registry for New Jersey

CAROL H. YEE, M.P.H.

RONALD ALTMAN, M.D., Trenton*

The New Jersey State Department of Health has been mandated legally to establish a statewide Cancer Incidence Registry. The purposes of the Registry, its source of information, and the role of New Jersey physicians are described.

As a consequence of the enactment of Public Laws of 1977, Chapter 266, the State Department of Health is establishing a Statewide Cancer Incidence Registry which will collect, tabulate, and, utilizing computers, analyze basic data on all newly diagnosed cancer occurring among New Jersey residents.

There are many questions that can be answered with information gathered by a statewide registry. What is the true incidence of cancer in New Jersey? How do the different forms of cancer vary in their pattern of occurrence by age, race, sex, and the passage of time? Which geographic sections of the state and which population groups are experiencing excess cancer occurrence? Have the incidence rates of specific cancers risen or fallen over the past several years?

From answers to such questions, we can pick up clues and generate hypotheses about possible etiology. We can define where control measures, such as education and diagnostic programs, and prevention measures may be most effective. Baseline data will be available for epidemiologic studies by qualified investigators. Summary feedback information can be provided to hospitals and their medical staffs. Registry data can be used to plan and monitor the effectiveness of cancer control programs, such as screening programs.

Regulations recently were adopted defining the reporting requirements. Reports will come from hospitals and other health care facilities, from physicians seeing patients with cancer who are not hospitalized in New Jersey, and from

independent clinical laboratories. The law provides immunity from liability for those reporting information under the law.

Since most patients with cancer are admitted to hospitals, the majority of case reports will be sent from hospitals. When a case of cancer first is seen in any given hospital, it is to be reported. No subsequent reports are required on an individual except when a new primary tumor is diagnosed. The hospital tumor registrar or an individual in the medical records department will abstract information from the medical record onto the standard form provided by the State Department of Health or onto a hospital tumor registry abstract form. A copy of the pathology or hematology report is to be attached in those cases having laboratory confirmation. The information to be reported is basic patient identification, demographic data, and diagnostic information on the tumor. Written guidelines, training workshops, and field representatives will assist with achieving uniform reporting.

As cancer case reports are received by the State Registry, they shall be handled in a confidential manner as provided by law. As the maintenance of confidentiality is of utmost importance, safeguards will be implemented at all phases of registry operation. Reports will be checked for duplication, accuracy and completeness, and computerized. Death

*From the New Jersey State Department of Health, Trenton, where Ms. Yee is a research scientist with the Cancer Registry Program and Dr. Altman is director of Epidemiologic Services.

certificate information will be obtained from the Vital Statistics Division of the State Department of Health and added to the cancer case reports. Death information will be forwarded to hospital tumor registrars to assist with their follow-up of cancer patients.

Physicians are to report those cancer cases coming under their care who have not been hospitalized for cancer or who will not be referred to a hospital in New Jersey. As this will represent a small percentage of the cancer cases in the state, most physicians will not be involved directly in reporting to the State Registry.

Physician involvement is important in other ways. The State Cancer Registry requires high-quality data from hospi-

tal registries and medical records' departments which in turn rely on the availability of timely, complete, and accurate information from the medical record. Assistance will sometimes be needed by hospital registrars and medical records' personnel in interpreting diagnostic information in the record. Physician support in these areas not only will aid the State Registry but also the hospital registry and medical records department in their tasks.

Since cancer control, which includes prevention, early diagnosis, improved treatment and care, is the ultimate goal of all medical professionals involved in the cancer field, the Statewide Cancer Incidence Registry will be a valuable resource for planning and assessing cancer control activities.

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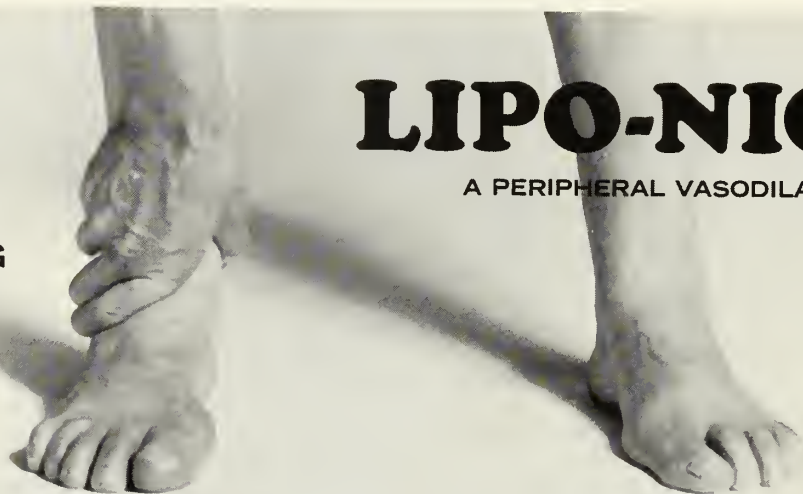


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Impact of the Health Professions Educational Assistance Act of 1976 on Medical Manpower in New Jersey

EDWARD COHEN, M.A.,
LEWIS DARS, Ph.D.,
JON TOMSON, M.U.P.,
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New Jersey is uniquely dependent on foreign medical graduates (FMGs). In 1976, three quarters of our new physicians were FMGs. The federal Health Professions Educational Assistance Act of 1976 limits the immigration of FMGs into the U.S. Its impact will be severe in New Jersey, unless actions are taken to change our FMG dependence. This paper offers alternatives to minimize the effect of this law on New Jersey's health care delivery system.

In 1976, Public Law 94-484, the Health Professions Educational Assistance Act of 1976, was signed into law by President Ford. The act affects many important health manpower issues. However, from New Jersey's viewpoint, the most pressing concern created by this legislation is Title VI. This section of the law revises the U.S. Immigration and Nationality Act in order strictly to limit the number of foreign-born physicians permitted to enter the country to practice medicine. As a result, New Jersey, which is dependent upon foreign medical graduates (FMGs) for a majority of its newly licensed physicians and hospital house staff, is facing a potential reduction in physician manpower and inpatient hospital services. This paper analyzes the impact of this legislation on medical manpower in New Jersey and explores a number of alternative policies which can minimize its effect on the State's health care delivery system.

MEDICAL EDUCATION IN NEW JERSEY

New Jersey was one of the last eastern states to establish a medical school. Until the mid 1950s when the Seton Hall College of Medicine was established, there was no academic medical center in the State to educate physicians and to enhance the State's hospital residency programs. In 1954, the Seton Hall College of Medicine was established in Jersey City. Its first class of physicians was graduated in 1960. However, the enormous operational expense of running a medical school was far greater than the College's sponsor,

the Archdiocese of Newark, could afford. Therefore, in 1965, Seton Hall College of Medicine became the New Jersey College of Medicine and Dentistry as the State assumed control of the College and the financial responsibility for its continued operation.

Subsequently, an ambitious expansion program, involving both capital investments and dramatic increases in operating support, and the 1970 merger with Rutgers Medical School, enabled the renamed College of Medicine and Dentistry of New Jersey (CMDNJ) to grow to significant proportions. In 1976, CMDNJ enrolled over 800 medical students in its two medical schools. It currently graduates 180 new physicians annually, with an additional 93 graduating from its Fifth Pathway Program for U.S. citizens who have completed their medical educations abroad. When plans for allopathic and osteopathic programs in Southern New Jersey reach fruition, the College projects an increase in its total graduates to a level of 400 by 1985. While this represents a remarkable rate of growth in the short period since the State's first medical school began to enroll students, it still will not provide a sufficient supply of new physicians to meet the State's medical manpower needs.

*Mr. Cohen is Assistant Chancellor; Dr. Dars is Director, Mr. Tomson is Assistant Director, and Ms. Vasilenko is Program Officer, Office for Health Manpower, Department of Higher Education, State of New Jersey. The authors serve as staff to the Governor's Commission on Professional Health Services. Correspondence may be addressed to Mr. Cohen at the Department of Higher Education, P.O. Box 1293, Trenton 08625.

New Jersey always has been a net importer of physicians. Moreover, to a degree experienced in only a handful of other states, we have been overly dependent on foreign medical graduates rather than graduates of American medical schools. This dependence can be made most evident by looking at the proportion of FMGs in the State's graduate medical education programs (hospital internship and residency programs). In 1963, 53 percent of all filled internships were occupied by foreign medical graduates, in contrast to 19 percent nationwide, 37 percent in New York and 23 percent in Pennsylvania. Roughly the same percentages applied to New York and Pennsylvania residencies that year, while 70 percent of New Jersey residencies were filled with foreign medical graduates.¹ This situation continued throughout the sixties. In 1970, of all the fifty states, New Jersey had the largest proportion of foreign graduates in its residency programs, with a full 78 percent of these positions being held by FMGs. Only three other states had over half of their residency programs filled by FMGs, Delaware (66 percent), Rhode Island (60 percent), and New York (52 percent).² Fortunately, with the expanded output of the CMDNJ, this over-reliance on FMGs to fill residency openings has begun to subside. In 1975, for example, 66.5 percent of residencies were filled by foreign medical graduates, a decrease of over 11 percent from 1970. Last year, this proportion was reduced further to 62 percent.³ While these gains are impressive, it is evident that there is still a long way to go before New Jersey brings its dependence on FMGs to a more reasonable level.

THE HEALTH PROFESSIONS EDUCATIONAL ASSISTANCE ACT OF 1976

Nationally, the proportion of FMGs in residency programs has stabilized at a level of one out of three positions.⁴ During the same period, output from American medical schools increased substantially. This expanding pool of American graduates and growing concern about the varying competence of FMGs focused public and professional attention to the wisdom of policies which encouraged the entrance of FMGs into the United States. In 1974, *The New England Journal of Medicine* published an article which voiced these concerns:

"Relatively uncontrolled entrance into the United States medical care system by FMGs of widely varying training, background, and competence is severely diluting the quality of the United States health care system. Even by the crudest measures of input, process, and certification examinations, it is apparent that many FMGs do not come close to the minimal standards set for United States medical graduates."⁵

The article concluded with a call for certification programs for FMGs, the institution of fiscal policies to compel institutions to employ only fully licensed FMGs, and a reduction in the number of residency program offerings in conformance with projected national manpower needs by specialty. While this article and others like it were disputed, they began to set the tone for public policy discussions which influenced the development and intent of the new health manpower law.

In 1976, Public Law 94-484, the Health Professions Educational Assistance Act of 1976, was signed into law. This legislation concerns itself with a number of health manpower issues. The law sets federal capitation support for schools of medicine, osteopathy, optometry, podiatry, pharmacy, veterinary medicine and public health. It also sets criteria for the continuation of scholarship and loan programs for health professions' students. The Act defines criteria for health manpower shortage areas and establishes a National Health Service Corps to help alleviate these shortages. From New

Jersey's viewpoint, however, the most pressing concern created by this legislation is Title VI which sets new entry requirements to be met by foreign physicians immigrating to the United States.

Title VI amends the Immigration and Nationality Act by requiring that all alien physicians wishing to enter the country as permanent immigrants can do so only after: (1) passing Parts I and II of the National Board of Medical Examiners Examination, or its equivalent, which now is called the Visa Qualifying Examination; and (2) demonstrating oral and written competence in English. Title VI also provides that alien physicians who wish to enter the country as exchange visitors (on J-Visas) to engage in residency programs must: (1) have a written agreement from an accredited medical school and any one of its affiliated hospitals guaranteeing placement in a program; (2) pass the Visa Qualifying Examination; (3) demonstrate competence in written and oral English; (4) make a commitment to return to his or her country of origin upon completion of residency training and obtain written assurance from said country that there is a need for persons with the skills obtained from that training in the country; (5) comply with a two-year limit of the J-Visa, with the possibility of a one year extension.⁶ The effective date of these J-Visa requirements was delayed through January, 1978. Also, the possibility of case-by-case waiver of these requirements remains through 1980, if a hospital can prove that a substantial disruption of services would occur if the regulations were implemented immediately.

AREAS OF IMPACT OF P.L. 94-484 ON NEW JERSEY

Recognizing New Jersey's history of dependence on FMGs to fill residency spaces, it is anticipated that the implementation of this law will disrupt graduate medical education in the State. The State's ability to attract American medical graduates and to fill all available residency positions continues to be a problem. Data from the 1978 Residency Matching Program show that New Jersey was able to fill 289, or 68 percent of its 423 available first-year positions. In the primary care specialties (Family Practice, Internal Medicine, OB/GYN, and Pediatrics), 198 out of 264 positions, or 75 percent of our openings were filled. These rates are roughly comparable to those of our neighboring states (i.e., in Pennsylvania, 664 (74 percent) of the 894 available positions were filled and 84 percent of the 108 primary care slots were matched). There are other situations in graduate medical education which will become problem areas as the legislation is implemented fully. For example, one-half of our 900 primary care residency positions currently are held by alien foreign medical graduates. There are twelve primary care residency programs in New Jersey which are not affiliated with a medical school, each of which will be in jeopardy with the new law. Not only is the future of non-affiliated programs questionable, but those affiliated programs with large proportions of FMGs may be forced to close unless they can attract greater numbers of American medical graduates.

The effect of the new regulations will go far beyond our graduate medical education network. A recent study by the New Jersey Department of Higher Education estimates that by 1982 New Jersey may be facing a situation where the number of physicians leaving the workforce (i.e., due to death, retirement) will exceed the number of newly licensed physicians entering practice in the State. The report states that approximately 75 percent of our newly licensed physicians are FMGs, of whom only one-fifth are American-born

FMGs. It estimates that New Jersey will be facing a 48 percent reduction in the annual number of newly licensed physicians once these regulations are implemented fully. This means that the ratio of physicians to population in New Jersey, which was projected to grow to 200 physicians per 100,000 persons by 1985, actually will be 179 physicians per 100,000 compared to the 1985 national rate projected at 220 physicians per 100,000.⁷ It is evident, therefore, that anticipatory actions are needed to ease the impact of this new legislation on New Jersey.

PROPOSED POLICY OPTIONS FOR THE SOLUTION OF THE FMG PROBLEM

The growth of CMDNJ in the northern, central and southern parts of the State and its developing network of hospital-based affiliated residency programs will continue to add significant numbers of personnel to our total supply of physician manpower. We have seen, however, that this growth will not offset the loss of personnel resulting from the implementation of Title VI. The questions that must be addressed are how to close the gap between the needs of our citizens and the available supply of services and, further, how to accomplish this task in a cost-efficient manner. There are a number of possible policies which can address the FMG problem. These include policies that would result in increased physician productivity; programs that would improve the State's supply and retention of physician manpower; and, policies that would promote different modalities to ease the demand for hospital-based, inpatient care.

Besides the application of more advanced medical technology, the use of alternative personnel has become an acceptable and significant means in which to increase the physician's capacity to provide health services. This approach is not new. Historically, physicians have trained individuals to assist them in their practices and have delegated various tasks and functions to these people. Today such personnel are known as physicians' assistants, nurse practitioners, or nurse clinicians. While there are differences both in the tasks these individuals perform and their level of dependence on (or independence from) the physician, they can and do provide many services now being performed by physicians. With respect to these personnel, the following options are possible:

1. Promote the Use of Physicians' Assistants—National studies indicate that the productivity impact of physicians' assistants (PAs) can range between 30 and 50 percent.⁸ In other words, the use of a PA by a physician could increase the number of patient visits by that percentage range, by freeing the physician from the more routine time-consuming tasks. Similar results were found in a study conducted by the New Jersey Department of Higher Education on the need for nurse practitioners and physicians' assistants.⁹ The data presented in these reports also imply that, with the appropriate number of PAs, the current and projected demand for health care services could be delivered with fewer physicians.

At the present time, New Jersey is the only state which does not permit PAs to practice. Since 1975, however, the State has supported a joint CMDNJ-Rutgers University four-year baccalaureate program preparing primary care PAs. In June of 1977, the first class of 15 PAs was graduated, and those who wished to pursue their careers were forced to leave the State to find employment. In light of the existing body of data concerning the usefulness of these individuals and the availability of educational resources to

train them, the enactment of legislation permitting these personnel to be employed within the State should be considered.

2. Encourage the Employment of Other Health Personnel—Nurse practitioners should be used in hospitals to the limit of their knowledge and skills. If necessary, changes in the Nursing Practice Act should be developed in order to provide for this possibility. Furthermore, other health professionals whose functions would lessen the burdens of the medical staff should be identified and either legislative or regulatory changes be recommended to allow these professionals to practice.

3. Change the Reimbursement Mechanism—In December, 1977, federal legislation was enacted permitting Medicare/Medicaid reimbursement for services provided by physicians' assistants and nurse practitioners in rural, medically underserved areas. These services, also may be reimbursed if provided within the context of demonstration programs in urban areas. Such changes in the reimbursement mechanism provide physicians and health care facilities with a strong inducement to employ these personnel. Within the limits of the practice acts, changes in the State's reimbursement regulations should be considered to encourage the use of these personnel in hospitals and ambulatory care settings by permitting third-party reimbursement for their services.

The second area of policy considerations deals with procedures affecting the supply and retention of physicians. There is a growing body of evidence that demonstrates that the historical shortage of physicians in the United States is rapidly coming to an end.¹⁰ In light of this trend, national priorities are shifting from policies designed to eliminate an aggregate shortage of manpower to those that seek to correct the geographical and specialty maldistribution of personnel. At the state level, however, New Jersey continues to be confronted with both issues as the projected shortage of physicians will become more severe in the future. There are policy options which would increase the physician supply in New Jersey and improve our retention of a larger number of physicians:

1. Increase the Production of Physicians at the CMDNJ—The current graduating class at the CMDNJ is 265 physicians per year and with the addition of the allopathic and osteopathic programs in the South this total could increase to 400 by 1985. The possibility of increasing physician production up to the maximum permitted by present physical plant size should be explored.

2. Improve Our Ability to Attract and Retain Physicians in New Jersey—In order to retain a larger percentage of the physicians currently trained in New Jersey and to attract more American medical graduates from other States, programs that will make it financially attractive for physicians to locate in the State and programs to improve the quality of the State's residency training programs must be considered. This can be accomplished in a number of manners, such as: (a) Offer financial incentives to attract young physicians to places where they are needed. For example, this may be possible by developing mechanisms such as a loan-redemption program for medical students which requires their services in the State in exchange for redemption of their educational loans.

(b) Provide incentives to hospitals for improving graduate medical education programs to increase their attractiveness to both in-state medical graduates and out-of-state medical graduates. In February, 1978, Governor Byrne signed into law a bill establishing a Graduate Medical Education Pro-

gram in New Jersey (P.L. 1977 Ch. 390). The intent of the legislation is to provide competitive grants-in-aid to residency programs affiliated with medical schools to offset partially the educational costs of such training. While the program is voluntary, it is a first step toward creating a coordinated network of quality graduate medical education programs.

There is one other policy area which offers a means to limit the impact of this federal legislation. Many health care authorities contend that a number of services currently delivered on an inpatient basis can be delivered efficiently (i.e., with less physician input) and more economically in an ambulatory care setting. This final set of policy options, while not comprehensive, is suggestive of how current demand for hospital-based care can be shifted to these ambulatory settings.

1. Additional Changes in the Rate Reimbursement Structure

—Probably the principal factor contributing to our utilization of inpatient services is the current system of rate reimbursement. It has been found that hospital admission rates in the United States are among the highest in the world, while our length of stay is the lowest.¹¹ These data suggest that we tend to rely upon a highly expensive mode of delivery for many uncomplicated procedures, in large part because the consumer is reimbursed fully only if these services are provided on an inpatient basis in a hospital. It would appear to follow, therefore, that the reimbursement rate structure could be changed to create an incentive for the hospital and the physician to shift more surgical and diagnostic services to outpatient clinics and other ambulatory care settings. This would permit an increase in the patient load for any one physician, particularly if that physician can delegate some services to physician support personnel.

2. Using a Peer Review System to Constrain the Demand for Inpatient Care

—The development of the concept of Professional Standards Review Organizations (PSROs) is designed to meet the need for quality assurance in the delivery of care. According to the Department of Health, Education and Welfare, the essential goals of the PSROs are to determine, "whether the services are medically necessary; whether they conform to professional recognized standards; and whether they are provided in the most appropriate care setting."¹² Consistent with these goals, PSROs might be encouraged to use their authority to examine patterns of hospital utilization and length of stay policies, and develop recommendations that would result in fewer inpatient admissions. If this could be accomplished, hospitals would experience a reduced demand for physician personnel.

3. Promoting the Development of Health Maintenance Organizations

—Health Maintenance Organizations (HMOs) likewise appear to provide an opportunity to reduce directly our demand for physician manpower. By providing comprehensive coverage within the constraints of a fixed budget, the HMO has an incentive to deliver services most efficiently. Furthermore, the prepayment concept insures that health education and continuous health maintenance will be stressed in order to hold down future levels of utilization.

CONCLUSION

Recent data indicate that the implementation of the new federal health manpower law, which strictly will limit the immigration of alien physicians into the U.S., will have a serious effect on the State's future supply of physicians. Since New Jersey has relied so heavily upon an unrestricted flow of

foreign physicians for a majority of its newly licensed physicians and hospital residents, the State may be faced with both an overall shortage of physicians and an acute shortage of hospital house staff before 1985.

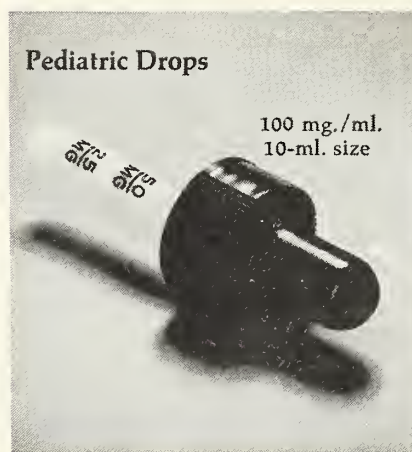
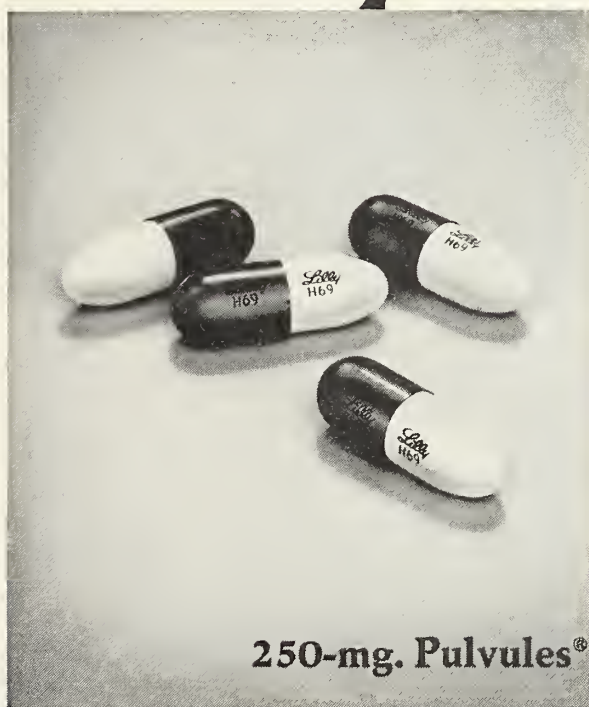
In this paper, we have reviewed a number of policy considerations which can be explored in the near future in order to deal with this evolving problem. A number of state agencies, regulatory bodies, and lawmakers must be involved to address these policy options. Together with input from the concerned professional societies, associations, and other constituent groups, the State's policy makers can begin effectively to address the physician manpower shortage anticipated as a result of the Health Professions Educational Assistance Act of 1976.

Movement already has begun in this area with Governor Byrne's issuance of Executive Order #58, which establishes a Commission on Professional Health Services. The Commission is charged with the responsibility to develop recommendations to counteract the potential loss of physician manpower resulting from P.L. 94-484. During 1978, the Commission will be considering numerous policy options to meet its responsibility. It is anticipated that its final deliberations will help New Jersey to confront the problems resulting from the manpower legislation with minimal impact on our service delivery and educational systems. In part, the degree to which the Commission and other responsible public agencies will be able to solve the physician manpower dilemma will be contingent upon the quality of the advice and recommendations brought forth from effected organizations and institutions, including organized medicine.

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Plain Film Diagnosis of Congestive Heart Failure*

HUGO SPINDOLA-FRANCO, M.D., Bronx, New York**

The purpose of this item is to demonstrate to practicing physicians the variety of techniques available to establish a clinical diagnosis in cardiology without the need for the more elaborate and potentially hazardous invasive techniques.

A 68-year-old male presented with a history of previous myocardial infarctions. During the second infarct he developed congestive heart failure and was prescribed a low-salt diet and oral diuretics. He did well on this regimen for several years. Following a flu-like syndrome and dietary indiscretion, he developed progressive shortness of breath.

On admission to the hospital he was found to be dyspneic at rest. His heart rate was 110 beats/min. The heart was enlarged to palpation, with the point of maximal impulse (PMI) in the sixth intercostal space outside the mid-clavicular line. A diastolic gallop was present, but there were no murmurs. There were coarse rhonchi and wheezes over both lung fields posteriorly, with fine inspiratory rales at both bases. The ECG showed sinus tachycardia and evidence of an anterior wall myocardial infarction which was unchanged from a previous tracing. A chest x-ray was obtained (Figure 1).

Following therapy a repeat x-ray was obtained (Figure 2).

NORMAL PULMONARY VASCULATURE

Even though the distribution of the pulmonary veins and arteries is uniform throughout the lungs, their perfusion differs. Bjure and Laurell³ observed that in the erect position the bases of the lungs were better perfused than the apices. They thought that this phenomenon was due to gravity.

Because of the gravitational dependence of the distribution of pulmonary flow, the vessels to the lower lobes are significantly larger than those to the upper lobes. Radiograph-

ically, the lower lobe vessels, particularly near the hilum and the left atrium are clearly visualized, whereas those in the upper lobes may be difficult to identify because of their small size. The pulmonary vessels taper gradually from center to periphery. At no point is there any abrupt change in caliber.

INCREASED PULMONARY RESISTANCE

The appearance of the pulmonary vasculature on plain films varies with the site of origin (pre-or post-capillary) and degree of the increased resistance.

Pulmonary venous hypertension (PVH) may result from any cause producing an increased pressure beyond the

³Bjure A and Laurell H: Abnormal static circulatory phenomena and their symptoms: Arterial orthostatic anemia as neglected clinical picture. *Upsala Lakaref Forh* 33:1-23 (Sept.) 1927—Quoted by Milne ENC: Correlation of physiologic findings with chest roentgenology. *Radiol Clinics NA* 11:17-47 (Apr.) 1973.

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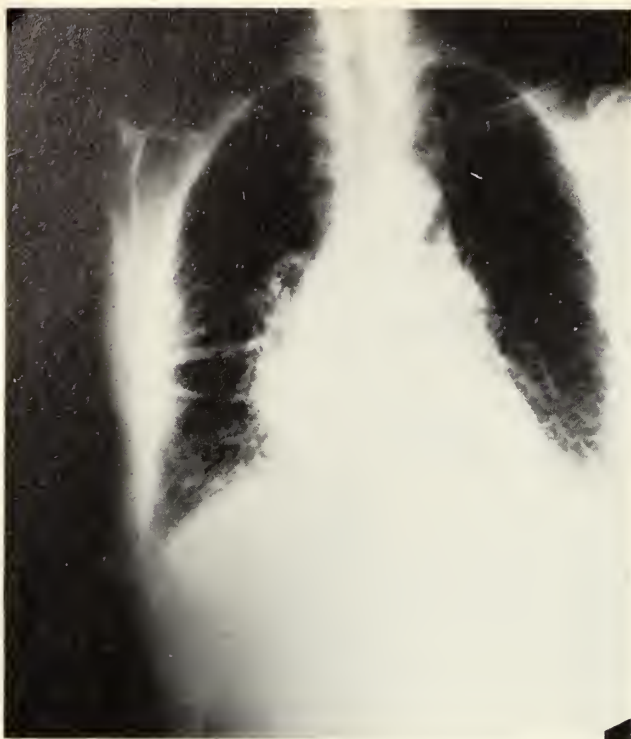


Figure 1—P.A. chest roentgenogram of a 68-year-old male with moderate to severe pulmonary venous hypertension secondary to left ventricular failure, (pulmonary capillary wedge mean pressure 20-30 mmHg). The radiographic diagnosis of pulmonary venous hypertension is based on the presence of subpleural edema (fluid in the interstitium adjacent to the pleural surface of the minor fissure), Kerley lines, interstitial veiling, hilar haze, and a small left pleural effusion. Moderate cardiomegaly with left ventricular prominence is seen.



Figure 2—Following medical therapy, the signs of pulmonary venous hypertension have cleared.

capillary bed. Left ventricular failure (from any cause) and mitral valve disease are the most common etiologies. Radiographically, PVH may appear as pulmonary vascular redistribution, pulmonary edema (interstitial and/or alveolar), and pleural effusion. Pulmonary hemosiderosis and ossification are secondary late manifestations.

Normally the lower lobe vessels are up to four times more prominent than the upper. Pulmonary vascular redistribution is characterized by dilation of the upper lobe vessels. The vessels of the lower lobes are normal or markedly constricted. This reversal of the normal relationship is secondary to an elevation of the pulmonary venous pressure causing interstitial and perivascular edema, which occurs first in the lung bases because of the greater hydrostatic pressure. The perivascular edema causes compression of the pulmonary capillaries in the lower lobes. Consequently, there is an increase in the pulmonary vascular resistance in the lung bases and blood flow is diverted or redistributed to the upper lobes, which have a lower resistance. The degree of pulmonary vascular redistribution is an index of the severity of venous hypertension.

Interstitial pulmonary edema may be septal (Kerley's lines), sub-pleural or perivascular. Septal lines are distended interlobular septa; they may be due to interstitial fibrosis, hemosiderosis, lymphangitic metastatic spread, lymphatic obstruction and interlobular interstitial edema secondary to venous hypertension. Septal lines are, therefore, nonspecific. They are sharp, linear densities about one mm in width and two to three cm in length extending from the pleural surface toward the center of the thorax.

They usually run transversely in the frontal projection. They are more common in the costophrenic angles.

Perivascular edema produces "interstitial veiling" and loss of sharpness of both the central and peripheral vessels (perivascular cuffing). There may be loss of definition of the clear space between the right hilus and the heart (perihilar haziness).

Subpleural edema (Figure 1) is the accumulation of fluid between the lung and the adjacent pleural surface (interlobar thickening). It should be differentiated from encapsulated interlobar effusion (pseudo-or vanishing tumor) and middle lobe collapse. Interlobar effusion has biconvex margins (spindle-shaped).

The degree (mild, moderate or severe) of pulmonary venous hypertension and the response to medical therapy can be estimated by a careful analysis of chest roentgenograms.

In mild pulmonary venous hypertension (12 to 20 mm Hg mean pulmonary capillary wedge pressure) there is: (a) an equal perfusion of the upper and lower lung zones (uniform caliber of both upper and lower pulmonary vessels on the chest film), and (b) redistribution of the pulmonary blood flow to the upper lobe vessels (reversal of the normal pulmonary flow pattern; there is dilatation of the upper lobe vessels and constriction of the lower lobe vessels). Moderate pulmonary venous hypertension (20 to 30 mm Hg mean wedge pressure) is characterized by the presence of interstitial edema (septal lines of Kerley), pulmonary "interstitial veiling," subpleural edema, perihilar, perivascular and peribronchial haziness, and small pleural effusions. In severe chronic pulmonary venous hypertension (mean pulmonary wedge pressure greater than 30 mm Hg) alveolar edema and large pleural effusions are seen. Because of the sudden elevation of pulmonary venous pressure in acute left heart failure, pulmonary alveolar edema may be the sole manifestation of cardiac decompensation.

Cancer and Anorexia

ATHANASIOS THEOLOGIDES, M.D., Ph.D.,* Minneapolis

Anorexia is a common manifestation of cancer. It can be one of the presenting symptoms inducing the patient to seek medical advice or it may appear as the disease progresses. The symptom of easy filling, or early satiety, is another intriguing feature; despite being hungry at the beginning of the meal, the patient rapidly "feels full" and develops an aversion to more food. These two symptoms are observed in about 40 percent of patients whose cancer has recurred or spread.¹

With radiotherapy or chemotherapy and with further progression of the disease, both the incidence and the severity of these symptoms increase. The anorexia and early satiety cause a drop in food consumption and this oligophagia, along with other factors, contributes to the progressive tissue wasting and the eventual cachexia, which has become the hallmark of advanced cancer.²

The major clinicopathologic characteristics of cancer cachexia are anorexia, early satiety, increased basal metabolic rate and energy expenditure despite the reduced caloric intake, loss of body protein, fat and other components leading to a significant weight loss, abnormalities in carbohydrate metabolism, water and electrolyte abnormalities, anemia, and marked asthenia. One-third to two-thirds of patients with various cancers are cachectic at death and their anorexia had contributed significantly to the development of this syndrome.

If the normal mechanism of the genesis of hunger and satiety were clearly delineated, then it would be easy to understand the pathogenesis of anorexia in cancer. However, major phases of the mechanism, which normally regulate the food intake, remain hypothetical. Simply stated, we don't know the physiology of how we get hungry and why we become satiated, although several theories have been proposed.

It is well established that the brain has a central regulatory system with hypothalamic nuclei playing a major role in the genesis of the sensation of hunger and satiety, operating in a reciprocal excitation/inhibition system and with higher centers exerting modifying influences.³ However, the signals and messages that activate or suppress feeding and satiety centers in the brain for the most part remain speculative. Various central and/or peripheral neural, physical and chemical signals and messages have been proposed as being the link between the state of the body of needing more food and the state of the body in which adequate nutrients were replenished. In the former case, the sensation of hunger is gener-

ated; in the latter, that of satiety.

Sensations from the oropharyngeal regions, the stomach and the intestine were considered as creating a sense of hunger and as having a regulatory role in metering the quantity of food eaten on a meal-to-meal basis. However, since the regulation persists after total gastrectomy and since animals will increase the amount of food consumed when their food is diluted with calorically inert materials, their role cannot be crucial.

The thermostatic hypothesis considered the heat released during the assimilation of food—the specific dynamic action of food—to be the force that regulates the food intake on a day-to-day basis. Simply stated, "animals eat to keep warm and stop eating to prevent hyperthermia." However, this hypothesis cannot explain the increased food consumption in hyperthyroidism and with muscular exercise despite an increased heat release in both cases.

A proposed regulation by osmoreceptors emphasized that water concentration or shift of water from intracellular to extracellular compartments was the source of satiety signals to the brain. The glucostatic regulation stressed that the rate of glucose utilization, the "effective blood sugar," provided the link between the supply of nutrients and the hypothalamus, while the lipostatic regulation postulated a circulating humoral factor to be in dynamic equilibrium with the total adipose tissue in the body. This factor supposedly is the signal for the brain centers, whose primary long-term regulation is the stabilization of fat stores. For the amino acid regulation, the concentration and the pattern of amino acids in the blood and extracellular fluids were considered to be the important signals for food intake regulation, while insulin, growth hormone, glucagon, enterogastrone and cholecystokinin were considered as factors inducing hunger or satiety and as being important in the short-term regulation of food intake in the hormonal regulation theory.

However, all of these as well as other theories leave unanswered major questions on the physiology and pathophysiology of hunger and satiety and none can explain the pathogenesis of the profound anorexia of cancer.⁴

The author has advanced the hypothesis that peptides, oligonucleotides, and other small metabolites produced by the cancer are responsible for the genesis of anorexia of

*Reprinted with permission of *Contemporary Nutrition* 2:4 (April) 1977, a newsletter from the Nutrition Department of General Mills, Inc., Minneapolis. Dr. Theologides is Professor of Medicine, University of Minnesota Medical School, Minneapolis.

cancer.⁵ The synthesis of these peptides may be the result of derepression of various cancer cell genomes or if one accepts a viral etiology of cancer, peptides may result from virus-directed protein synthesis.

These small molecules may induce the anorexia indirectly through an effect on peripheral neuro-endocrine cells or neuro-receptors and through a direct effect on the hypothalamic and higher central nervous system satiety and hunger centers. The cells of these centers may act both as sensors and responders, sensing the presence of peptides and other metabolites and responding by generating cyclic AMP or new peptides, which might stimulate or suppress adjacent or distant neurons, eventually creating in the brain the sensation of satiety and anorexia.⁵

The direct relationship of the anorexia to cancer is appreciated better when it is present prior to the diagnosis and when it disappears following a curative resection. However, following the diagnosis of this dreadful disease, profound emotional and psychological factors such as depression, anxiety, grief, and so on may affect the appetite adversely.

The presence of cancer induces changes in the sense of taste, which also has an adverse effect on appetite.⁶ This disturbance of the sense of taste also may appear following radiotherapy to the oropharynx and during chemotherapy. Although patients with cancer frequently complain that they cannot stand the smell of certain foods, no critical research has been done regarding any olfactory sensory changes that may cause aversion to certain foods, especially to meats.

Anorexia also may appear when there is significant replacement of the liver by metastatic tumor or when there is significant hepatotoxicity from the prolonged use of certain antineoplastic agents such as methotrexate.

Moreover, radiotherapy and chemotherapy adversely affect food intake since, as a rule, they induce anorexia, nausea, and frequently vomiting. A conditioned aversion to eating may develop in patients who for various reasons experience nausea, discomfort, or pain during or after eating. This conditioned aversion may be mistaken for anorexia because it may persist even after the causative factor has been removed or alleviated and may require behavior modification therapy. Supportive medications such as anti-depressants, tranquilizers, analgesics and sedatives may occasionally decrease appetite. With so many causes for anorexia, it is not surprising that cancer patients frequently develop malnutrition. Furthermore, the patient by failing to ingest enough nutrients, fails to provide enough supplies for the energy needs and develops a negative energy balance.

Maintenance of good nutritional health for as long as possible is to the patient's advantage because malnourished

cancer patients do not tolerate surgery, radiotherapy and chemotherapy as well as those in a better nutritional state. The malnutrition adversely affects not only tissue function and repair but also humoral and cellular immunocompetence, causing changes in drug metabolism and tolerance through alterations in the activity of hepatic microsomal enzymes.⁷

Only the successful surgical, radiotherapeutic or chemotherapeutic cure or control of cancer can reverse the anorexia and result in increased food intake for there are no appetite stimulating drugs that can overcome the profound anorexia of cancer. When pharmacologic doses of adrenal corticosteroids are given because of other indications, a marked stimulation of appetite is observed, but this, too, is transient.

Specific therapy may have a beneficial effect on appetite when specific complications are identified as contributing to the anorexia. However, the patient usually is advised to introduce the approach of nibbling a variety of highly nutritious foods rather than attempting to eat widely spaced large meals.

Feeding the patient through a nasogastric tube or performing feeding gastrostomy or jejunostomy are used occasionally when clinically indicated and justified. Parenteral hyperalimentation and elemental diets are also new promising approaches for the nutritional management of selected patients with advanced cancer.

In summary, profound anorexia leading to malnutrition is a common and disturbing manifestation of cancer and has a poorly understood pathogenesis. Considered an ominous sign by the cancer patient and his family, it creates a great anxiety.

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5. Theologides A: Anorexia producing intermediary metabolites. *Am J Clin Nutr* 29:552, 1976.
6. DeWys WE and Walters K: Abnormalities in taste sensation in cancer patients. *Cancer* 36:1888, 1975.
7. Theologides A: Nutritional management of the patient with advanced cancer. *Postgrad Med* 61:97-101., Feb. 1977.

Eye Health Screening and Glaucoma*

For the 22nd year the Medical Society conducted an eye health screening program in 95 hospitals in New Jersey during the week of September 24, 1978.

This program has screened 201,260 patients. Of these, 110,860 had no positive tests, while 90,100 had a positive finding in one or more of the following categories: Visual Acuity, External Conditions, Ophthalmoscopy, and Tonometry. Tonometry tests produced 10,478 glaucoma suspects.

All screenings are given statements informing them that they have not had a complete eye examination. If a positive test is recorded, the patient is advised to seek further examination.

The screening program naturally turns up a high percentage of patients with refractive errors. However, large numbers of patients have been found with cataracts, corneal diseases, neurological problems, various types of retinopathy, and ocular tumors.

Perhaps the most important disease entity sought in the screenings is glaucoma, since it affects approximately one to one and a half percent of the population and in many instances produces marked visual loss and even blindness without symptoms. It is the leading cause of preventable blindness.

Primary glaucoma is classified according to the anatomical configuration of the angle of the anterior chamber. The majority of these cases have an open angle associated with a restriction in aqueous outflow through its channels. Since these cases are usually symptomless before severe visual field loss occurs, routine tonometry and examination of the optic nerve head is the only way to insure early detection. This is especially important in the more susceptible individuals, such as those with a family history of glaucoma, older age groups, systemic hypotension or hypertension, high myopia, and black patients. In a smaller number of patients,

the angle partially or completely closes, producing a pupillary block and a pooling of aqueous in the posterior chamber. The pressure rises rapidly, and the condition may manifest with slightly blurred vision and headaches or a more severe case with a red eye, cloudy cornea, dilated pupil, and severe headache. Patients with acute glaucoma often may develop nausea and vomiting. In susceptible eyes it may come on after the use of sympathomimetic drugs or following surgical procedures where atropine-like drugs have been used. Physicians should be aware of this possibility, so as not to neglect these symptoms in the post-operative patient.

Congenital glaucoma is not a common problem but should be considered in children with photophobia, large cornea, cloudy cornea, or cornea with evidence of cracks.

Secondary glaucoma represents a group of unrelated ocular conditions associated with increased intraocular pressure. Among the many causes are: (1) inflammatory disease, such as iritis and chorioretinitis; (2) trauma, both perforating and blunt; (3) swollen or leaking cataracts; (4) vascular diseases producing neovascularization, such as diabetic retinopathy and occlusive vascular diseases; (5) ocular tumors; (6) congenital or hereditary defects; and (7) steroids, either local or systemic. Secondary glaucoma usually results in these cases due to some type of mechanical block of the angle of the anterior chamber.

Visual loss due to glaucoma results from damage to the optic nerve. Currently it is considered to be due to an impairment of the circulation in and around the nerve head. Decreased perfusion of blood through these capillaries may be due to elevated intraocular pressure, low diastolic blood pressure, anemia, or hemodynamic crisis. Whether direct pressure on the nerve fibers can produce this damage is debatable. Damage to vision occurs when there is pathological cupping of the disc with concomitant visual field loss.

CMDNJ Notes**

Stanley S. Bergen, Jr., M.D.
President

CMDNJ's threefold mission is education, research, and service—a mission with the single objective to improve the availability of quality health care in New Jersey, and in the nation. This mission is visible mainly through the College's service facilities, which also illustrate CMDNJ's role as a participant in regional efforts of the state's total health care planning process. Two major facilities serving Northern New Jersey are CMDNJ-Martland Medical Center in Newark, which will be replaced by the new CMDNJ-College Hospital early next year as the primary teaching hospital of the CMDNJ-New Jersey Medical School, and the school's Community Mental Health Center.

Central New Jersey is serviced by the CMDNJ-Raritan Valley Hospital, Green Brook, which is the primary teaching hospital for the CMDNJ-Rutgers Medical School, Piscataway, and the school's Community Mental Health Center. Comprising the major service components in South Jersey are a network of affiliated agreements with hospitals and planned service education programs.

The College's relations to these three distinct areas of the state are as follows:

NORTHERN NEW JERSEY

Over the next five years, Martland/College Hospital will be developing expertise and tertiary level skill in five regionalized services: trauma, developmental defects, neonatology, the neurosciences, and cancer research and treatment.

*This item was prepared by Alfonse A. Cinotti, M.D., Professor and Acting Chairman, Department of Ophthalmology, New Jersey Medical School—CMDNJ, Newark, New Jersey 07103.

**This month's column is excerpted from Dr. Bergen's report to the State Health Coordinating Council of New Jersey, July 28, Hightstown.

Among the College Hospital's inpatient services will be a new 33-bed psychiatric unit for short-term treatment of adults, for which CMDNJ already has received a certificate of need. This unit is scheduled to be built atop the CMDNJ-Community Mental Health Center adjacent to and administratively part of the hospital.

A three-level cancer treatment center servicing statewide needs also will be built, pending approval by appropriate state agencies, next to the hospital. In addition, the hospital's radiology department is planning to expand its diagnostic capabilities to meet the demand required to support both the inpatient and outpatient units.

CENTRAL NEW JERSEY

CMDNJ entered into a major affiliation agreement last November with Middlesex General Hospital, New Brunswick, to establish that facility as the core teaching hospital for CMDNJ-Rutgers Medical School. Architectural plans now are being drawn for an education building adjacent to the hospital. This \$12-million structure, to house clinical science teaching and research areas, will be constructed with funds made available by the medical education bond issue which was approved by the voters last November.

Concurrently, Middlesex General will undergo a construction and renovation program, including a new emergency and ambulatory care center, for which it has received a certificate of need.

The College recognized from the outset that the 131-bed CMDNJ-Raritan Valley Hospital probably would not be able to fulfill the clinical requirements for training the increasing number of students and graduates from CMDNJ-Rutgers Medical School. CMDNJ is complying with the Commissioner of Health's stipulation that "an orderly process be initiated to determine the future role of Raritan Valley Hospital." Steps taken to address the issue include the appointment of an internal planning committee of clinical chairmen, a study of alternatives by the hospital's Long Range Planning Committee, a private consultant to report to the CMDNJ board of trustees, and the appointment of an ad hoc study committee of the county advisory committee of HSA-IV.

As outlined in several studies, it had been assumed that Raritan Valley would remain a College-owned hospital responsible for family medical care related to primary and secondary care associated teaching programs. However,

additional programs under consideration are those in occupational health, geriatrics, hospices, extended care facilities, and increased ambulatory services.

As the Middlesex General Hospital alterations are completed, the tertiary clinical programs at Raritan Valley will move there.

SOUTHERN NEW JERSEY

In South Jersey, CMDNJ's involvement is unique in that no College-owned health service facility is planned. Rather, the clinical needs of the two medical education programs—the CMDNJ-South Jersey Medical Education Program and the CMDNJ-New Jersey School of Osteopathic Medicine—are met through the development of affiliations with existing institutions.

Under the South Jersey Medical Education Program, 12 students from CMDNJ-Rutgers Medical School will begin taking their third-year clinical training this fall at Cooper Medical Center, Camden, which affiliated with CMDNJ in early 1977. Next year, a similar number of third-year students will begin training, which will result in a total of 24 third- and fourth-year students. Planning for third and fourth-year training has involved the appointment of a full-time Director of Family Medicine. Also this fall, 12 American-born graduates of foreign medical schools will receive clinical training at Cooper under the college's Fifth Pathway Program.

Students of the CMDNJ-New Jersey School of Osteopathic Medicine will begin their third-year training in the fall of 1979 at the John F. Kennedy Memorial Hospital, which became a major affiliate a year ago. First- and second-year osteopathic students receive their basic science training at CMDNJ-Rutgers Medical School.

It is anticipated that a major affiliation agreement also will be completed with the proposed Veterans Administration facility in Camden to provide the allopathic and osteopathic third- and fourth-year students with clinical training opportunities.

REGIONALIZATION

CMDNJ long has been committed to the concept of regionalization of selected health services and to the use of existing resources whenever possible. Regionalization has been cited as a means to provide significant reduction in the cost of the delivery of health care to the consumer. In addition, quality can be improved, economics of efforts can be

realized, and duplication of personnel, faculties, and equipment avoided.

In any attempt at regionalization of health services, consideration must be given to access of health professions' education. When an institution is given such a limited franchise it must be willing to accept students into that facility for training to assure a future supply of fully trained competent health professionals for New Jersey.

SUMMARY

As the state's major provider of health manpower and the only in-state source of physicians, the College is striving to meet the needs of the state in a variety of ways and with a focus on both the professional and the consumer. For instance, 95 percent of all students accepted into the various (six) schools of CMDNJ are New Jersey residents. Alumni records show that to date there are 593 graduates of CMDNJ-New Jersey Medical School in the state and 78 graduates of CMDNJ-Rutgers Medical School. Of those, 218 (or 32 percent) are primary care specialists

Report from the Foundation

Daniel J. O'Regan, M.D.
Medical Director

The IPA Consortium held its initial meeting in July. Dr. Richard H. Egdahl of Boston, a national authority on the prepaid concept, was keynote speaker. The Consortium is a voluntary organization of IPAs and IPA/HMOs throughout New Jersey. All such groups are invited to participate, regardless of their state of development. The purpose of the Consortium is to promote communication and exchange of information among the various groups. Drs. James Rogers and Victor Bressler are Co-Chairmen of the Consortium. Dr. Egdahl has agreed to act as consultant to the group. There are now 11 groups of interested physicians in New Jersey. The Consortium is the outgrowth of the IPA Study Group, which was established by NJFHCE several years ago. For further information, please contact Ms. Barbara Kempezinska, Assistant Director, NJFHCE, at the Foundation offices. A questionnaire on the subject of prepaid medical care and the Individual Practice Association (IPA) will be distributed. We will appreciate your response to this survey. You will receive reports through our Newsletter.

Physicians Seeking Location in New Jersey

The following physicians have written to the Executive Office of MSNJ seeking information on possible opportunities for practice in New Jersey. The information listed below has been supplied by the physician. If you are interested in any further information concerning these physicians, we suggest you make inquiries directly to them.

ADOLESCENT MEDICINE—Robert S. Smith, M.D., 39 Fairlane Drive, Wethersfield, CT 06109. Medical College of Virginia 1969. Special interest, adolescent psychiatry. Board eligible, pediatrics and psychiatry. Group, solo. Available July 1979.

ANESTHESIOLOGY—Anselma L. Canlas, M.D., 385 Wildrose Avenue, Bergenfield 07621. Santo Tomas (Philippines) 1969. Board certified. Group or partnership. Available January 1979.
Chien Hsin Tsai, M.D., 2327 Duke Street, Mason Gardens, Apt. F-3, Alexandria, VA 22314. Taipei (Taiwan) 1971. Board eligible. Group or partnership. Available October 1978.

CARDIOLOGY—Zouheir H. Elias, M.D., 4014 West 13 Mile Road, Apt. 11, Royal Oak, Michigan 48072. French Faculty (Lebanon) 1974. Subspecialty, internal medicine. Board certified (IM). Group, partnership. Available July 1979.

CARDIOVASCULAR DISEASES—Sae Kirl Kim, M.D., 8-C Borden Apartments, Third Avenue, Long Branch 07740. Chonnam University (Korea) 1967. Subspecialty, internal medicine. Board eligible (IM). Group, partnership. Available.
W. Bruce Fye, M.D., 307 Overbrook Road, Baltimore, Maryland 21212. Johns Hopkins 1972. Subspecialty, internal medicine. Board certified (IM). Group or institution. Available.
Anil G. Kothari, M.D., 9500 Euclid Avenue, Cleveland, Ohio 44106. Topiwala Medical School (India) 1972. Subspecialty, internal medicine. Board certified (IM). Group, partnership, institution. Available.
Michael M. Neumann, M.D., 5415 North Sheridan Road, Chicago, IL 60640. Dusseldorf (Germany) 1971. Subspecialty, internal medicine. Board certified (IM). Group or institution. Available November 1978.

DERMATOLOGY—Herbert A. Hochman, M.D., 351 East 84th Street, New York, New York 10028. Tulane 1970. Board certified. Solo, partnership, group (join or purchase). Available.

FAMILY PRACTICE—Ramzy Nasr Nabih, M.D., 126 Mingos Circle, Battle Creek, Michigan 49015. Cairo (Egypt) 1947. Board eligible. Group or partnership. Available.
Scott D. Kirsch, M.D., 19250-7 Hamlin Street, Riseda, CA 91335. SUNY (Buffalo) 1971. Board eligible. Partnership, group. Available January 1979.

Mark H. Krotowski, M.D., 7-29 Hegeman Ave., Apt. 3H, Brooklyn, NY 11212. Tel Aviv University 1976. Board eligible. Partnership, group. Available July 1979.
Dein M. Shapiro, M.D., 3400 Eastern Boulevard, Apt. C-9, York, PA 17402. Georgetown 1976. Single or multi-specialty group. Available.

GASTROENTEROLOGY—Drew P. Ronnermann, M.D., 275 Bryn Mawr Avenue, Apt. K-43, Bryn Mawr, PA 19010. NYU 1974. Subspecialty, internal medicine. Board eligible. Board certified (IM). Group or partnership. Available July 1979.
Ronald Roth, M.D., P.O. Box 8624, Academy Station, New Scotland Avenue, Albany, NY 12208. Albany Medical College 1974. Subspecialty, internal medicine. Board eligible (IM). Group, partnership, solo. Available July 1979.
David I. Reissman, M.D., 1763 Rolling Lane, Cherry Hill 08003. Albert Einstein 1974. Subspecialty, internal medicine. Board certified (IM). Group or partnership. Available July 1979.
John F. Schultheiss, M.D., Box 6, Second General Hospital, Landstuhl, West Germany. Wisconsin 1970. Subspecialty, internal medicine. Board certified (IM). Group, partnership, or solo. Available October 1979.

GENERAL PRACTICE—Joong Wan Kim, M.D., 220 Bolling Drive, Goldsboro, NC 27530. Busan Medical School (Korea) 1961. Subspecialty, dermatology. Board eligible (family practice). Solo, group. Available February 1979.
Jaw Yan Wang, M.D., 630 West Washington Street, Suffolk, VA 23434. Kaohsiung (Taiwan) 1971. Subspecialty, emergency medicine. Any type practice. Available.
Paul L. Maitheny, M.D., 99 Pawnee Rd., Lakewood 08701. Graz (Austria) 1951. Board eligible (psychiatry). Group. Available.
Jack A. Devor, M.D., 828 Cape View Drive, Fort Myers, Florida 33907. Hahnemann 1966. College or university health service. Available.

GYNECOLOGY—Charles I. Ware, M.D., 3325 Bayshore Boulevard, Apt. B-37, Tampa, FL 33609. University of Maryland 1948. Subspecialty, emergency medicine. Board eligible, obstetrics and gynecology. Group, partnership, emergency room. Available January 1979.

HEMATOLOGY—Mohan Singh Khurana, M.D., 6732 North Kendall Drive, Apt. C-110, Miami, FL 33156. All-India Institute (New Delhi) 1973. Subspecialty, internal medicine. Board certified (IM). Board eligible. Solo, group. Available July 1979.

INTERNAL MEDICINE—Marta Stekelman, M.D., P.O. Box 900, Hightstown 08520. Bs. As. Medical School 1959. Subspecialty, gastroenterology. Board eligible. Group, partnership, solo, research, hospital-based. Available.
Renuka Kumar, M.D., 8 Valley Park South, Bethlehem, PA 18018. University of Delhi 1970. Board eligible. Group, partner-

ship, hospital-based, solo. Available.
Edward B. Ruby, M.D., 9928 Sandy Road, Philadelphia, PA 19115. Jefferson, 1971. Subspecialty, endocrinology. Board certified (IM and endocrinology). Group or partnership. Available.
David C. Sobel, M.D., 181 Long Hill Road, Apt. 4-8, Little Falls 07424. SUNY (Downstate) 1976. Board eligible. Partnership or solo. Available July 1979.
Kim King Chan, M.D., 425 Goler House Apts., Rochester, New York 14620. Santo Tomas (Philippines). Board eligible. Group, solo, associate. Available.
Bhattacharya Y. Linganna, M.D., 742 South Cedarhill Drive, Allentown, PA 18103. Mysore (India) 1964. Subspecialty, family practice. Solo, group, emergency room. Available July 1979.
Edward B. Laub, M.D., 25-C Durham Drive, Williamsville, New York 14221. CMDNJ 1976. Group, solo. Available July 1979.
Karkada Jayarama Upadhyaya, M.D., 18-A 250 Ann Street, Easton, PA 18042. Bangalore (India) 1973. Subspecialty, emergency medicine. Group, partnership, emergency room. Available July 1979.
Leonard I. Raifman, M.D., 3333 Henry Hudson Parkway, Apt. 2-P, Riverdale, NY 10463. Guadalajara 1972. Subspecialty, cardiovascular diseases. Board eligible. Group, partnership. Available October 1978.
Hasmukh Jariwala, M.D., 222 Westfield Avenue, Roselle Park 07204. S.S. Medical College (India) 1971. Board eligible. Group, partnership, solo, emergency room. Available.
Tsuo-pin Lin, M.D., 1945 Corlies Avenue, Neptune 07753. Kaohsiung (Taiwan) 1971. Solo, partnership, group. Available July 1979.
Jeffrey D. Stahl, M.D., 2122 Cottingham Drive, Lyndhurst, Ohio 44124. Columbia 1974. Subspecialty, gastroenterology. Board eligible. Partnership, group, solo. Available July 1979.
William L. Liao, M.D., 1945 Corlies Avenue, Neptune 07753. University of Philippines 1972. Board eligible. Group, partnership. Available July 1979.
Maung Kyaw Aung, M.D., 5324 18th Avenue, Brooklyn, New York 11204. Institute of Medicine, Burma. Subspecialty, hematology/oncology. Board certified. Group, solo, hospital-based. Available July 1979.
Jeffrey S. Garbis, M.D., 1425 John Street, Baltimore, Maryland 21217. Guadalajara. Group, partnership, specialty, multi-specialty. Available July 1979.

NEOPLASTIC DISEASES—Stanley Ostrow, M.D., 9 Wytchwood Court, Baltimore, MD 21209. Downstate 1974. Subspecialty, internal medicine, oncology. Board eligible, oncology. Group or partnership. Available January 1979.

NEUROLOGY—Bharat M. Tolia, M.D., Westchester Medical Center, Valhalla, New York 10595. M.G.M. Medical College (India) 1970. Any type practice. Available July 1979.

OBSTETRICS/GYNECOLOGY—Kapila M. Patel, M.D., 609 Mix Avenue, Apt. B-1, Hamden, Connecticut 06514. Baroda (India) 1968. Board eligible. Group. Available.

Richard A. Peters, M.D., 3404 Glorus Place, Wheaton, Maryland 20902. NYU 1973. Board eligible. Group, partnership, institution, administrative. Available.

Yousef S. Banoud, M.D., 162 Sunset Avenue, Farmingdale, New York 11735. Ain-Shams University (Egypt) 1965. Board eligible. Partnership, solo, group. Available.

Antonin Dostal, M.D., 64 Elmwood Avenue, Outremont, P.Q., Canada H2V 2E5. Charles University (Czechoslovakia) 1967. Board eligible. Group, partnership, solo. Available March 1979.

Jeffrey M. Reinkraut, M.D., 40-01 Little Neck Pkwy., Little Neck, NY 11363. Rutgers (CMDNJ) 1975. Board eligible. Group or partnership. Available July 1979.

ONCOLOGY—Jorge G. Frank, M.D., 105 Lamb Street, Travis AFB, CA 94535. Subspecialty, neoplastic diseases. Board certified (IM). Board eligible. Group, partnership. Available June 1979.

OPHTHALMOLOGY—Peter J. Cetta, M.D., 7653 Normandie Boulevard, Apt. C-33, Middleburg Heights, Ohio 44130. CMDNJ 1975. Board eligible. Group, partnership, solo. Available July 1979.

David Sheldon Hyman, M.D., 113 Chelton Parkway, Cherry Hill 08034. Med. College of Virginia 1975. Group, partnership, solo. Available July 1979.

Steven Bert Siepser, M.D., 24-203 Delaire Landing, Philadelphia, PA 19114. Downstate 1974. Group, partnership, solo. Available July 1979.

Murray H. Rothman, M.D., 67-15 102nd Street, Apt. 75, Forest Hills, NY 11375. Albert Einstein 1974. Board eligible. Group, partnership, solo, research. Available August 1979.

Glenn S. Shear, M.D., Hollandale Apts. #7-B, Clifton Park, NY 12065. Albany Medical College 1975. Group or partnership. Available July 1979.

ORTHOPEDICS—Michael Glen Dolin, M.D., 100 Avenue P, Brooklyn, New York 11204. NYU 1970. Board eligible. Any type practice. Available.

OTORHINOLARYNGOLOGY—Naresh C. Goel, M.D., 1996A Village Green South, Providence, RI 02915. All-India Institute (India) 1973. Board eligible. Group, partnership, solo. Available December 1978.

PATHOLOGY—Kirit V. Solanki, M.D., 3635 West College Ave., Apt. 32, Milwaukee, WI 53221. B.J. Medical College (India) 1968. Board certified. Any type practice. Available.

PEDIATRICS—Abraham Nussbaum, M.D., Alpine Village, Apt. 2903, East Greenbush, NY 12061. Albany 1976. Board eligible. Group, partnership, solo. Available July 1979.

Vasanth K. Nalam, M.D., 822 Lincoln Road, Apt. 201, Bellevue, NE 68005. An-

dhra (India) 1969. Board certified. Group, partnership, institution. Available.

Kamran Tebbi, M.D., 1510 S. Belvoir Boulevard, South Euclid, Ohio 44121. Tehran (Iran) 1967. Subspecialty, hematology. Board certified. Group, partnership, solo, research, academic. Available October 1978.

Dolores Protagoras, M.D., 590 Fort Washington Avenue, New York, NY 10033. Wroclaw (Poland) 1965. Board certified. Group, research. Available.

PSYCHIATRY, ADOLESCENT—Robert S. Smith, M.D., 39 Fairlane Drive, Wethersfield, CT 06109. Medical College of Virginia 1969. Special interest, adolescent medicine. Board eligible, pediatrics and psychiatry. Group, solo. Available July 1979.

PSYCHIATRY—Vineet P. Kulkarni, M.D., 809 S. Marshallfield, Apt. 215, Chicago, IL 60612. Topiwala (India) 1972. Board eligible. Group, partnership. Available.

PULMONARY DISEASES—Mitchell L. Petusevsky, M.D., 5 Cragmore Road, Newton Highlands, Massachusetts 02161. NYU 1975. Board eligible (IM). Group or hospital-based. Available July 1979.

Gautam Desai, M.D., 74-38 43rd Avenue, Elmhurst, NY 11373. Baroda (India) 1970. Subspecialty, internal medicine. Board certified (IM). Board eligible. Group, solo. Available.

RHEUMATOLOGY—Richard K. Mastrole, M.D., 250 Cedar Ridge Drive, Apt. 509, Monroeville, PA 15146. University of Bologna (Italy) 1973. Subspecialty, internal medicine. Board eligible (IM). Group or partnership. Available July 1979.

SURGERY, CARDIOVASCULAR—Stewart Fox, M.D., Milton S. Hershey Medical Center, Hershey, PA 17033. Medical College of Virginia 1972. Subspecialty, thoracic surgery. Board eligible (general surgery). Group, partnership. Available August 1979.

Naweed Kamran Majid, M.D., Box 85, USAF Hospital, USAFE APO New York 09220. King Edward (Pakistan) 1967. Subspecialty, thoracic surgery. Board certified (general surgery). Board eligible. Group, partnership. Available August 1980.

SURGERY, GENERAL—Amelito P. Canlas, M.D., 385 Wildrose Avenue, Bergenfield 07621. University of Santo Tomas (Philippines) 1971. Board eligible. Group, partnership, solo. Available.

Kadankavil H. Joseph, M.D., 4410 Ogleshorpe Street, Apt. #504, Hyattsville, MD 20781. Trivandrum (India) 1970. Subspecialty, abdominal surgery. Board eligible. Group, partnership, research. Available.

Jose P. Arias, M.D., 42-55 Colden Street, Apt. 12-B, Flushing, NY 11355. Univ. of Buenos Aires (Argentina) 1968. Board eligible. Group, partnership, solo. Available December 1978.

Larry Alan Scher, M.D., 44 Lindsley Place, Irvington 07111. Med. College of Wisconsin 1973. Board eligible. Group, partnership. Available July 1979.

Marc David Rudich, M.D., Quarters 131-FE, Warren AFB, WY 82001. Albany Medical College 1971. Subspecialty, cardiovascular surgery. Board certified. Group, partnership, solo, institutional. Available June 1979.

Marc Howard Gertner, M.D., 2201 Pennsylvania Avenue, Apt. 407, Philadelphia, PA 19130. Ohio State 1973. Group, partnership. Available July 1979.

Virgilio S. Ipapo, M.D., 5 Bloomingdale Drive, Apt. 103, South Somerville 08876. Santo Tomas (Philippines) 1971. Board eligible. Group, partnership, institutional. Available June 1979.

Marcel Gardere, M.D., 12 Whitehall Avenue, Edison 08817. Faculte de Med., Haiti 1957. Subspecialty, general practice. Board eligible. Solo, partnership, group, emergency room. Available July 1979.

Rodolfo M. De Ocerá, M.D., St. Mary Medical Building, Suite 111, Newtown, Langhorne, PA 19047. Far Eastern University (Philippines) 1961. Subspecialty, general practice. Board eligible. Solo, partnership, group. Available February 1979.

Glenn Pasternack, M.D., 7660 Phoenix Drive, Apt. 1559, Houston, Texas 77030. SUNY—Downstate 1974. Subspecialty, vascular surgery. Board eligible. Group or partnership. Available July 1979.

SURGERY, ORTHOPEDIC—Ralph E. Sweeney, Jr., M.D., 9540 Indian Meadows, St. Louis, MO 63132. Georgetown 1973. Any type practice. Available August 1979.

Martin A. Cohen, M.D., 8201 Henry Avenue, Apt. M-22, Philadelphia, PA 19128. SUNY—Downstate. Board eligible. Group, partnership. Available.

SURGERY, THORACIC—James R. K. Condon, M.D., 498 Turner Loop, Fort Campbell, KY 42223. Albany 1968. Subspecialty, cardiovascular surgery. Board certified (general surgery). Board eligible. Group, partnership, research. Available July 1979.

SURGERY, UROLOGICAL—Gerald A. Goldman, M.D., 2913 Willowood Drive, Erie, Pennsylvania 16506. Guadalajara 1972. Board eligible. Association leading to partnership. Available July 1979.

Stephen J. Culver, M.D., 2018 La Grange Road, Dayton, OH 45431. University of Cincinnati 1972. Board eligible. Group, partnership, solo. Available July 1979.

Steven H. Paletsky, M.D., 126 C Remington Avenue, Syracuse, NY 13210. Medical University of SC 1973. Group or partnership. Available January 1979.

John A. Fracchia, M.D., 435 East 70th Street, New York, NY 10021. CMDNJ 1973. Group, partnership, solo. Available January 1979.

UROLOGY—Hassan Ismail Alsheik, M.D., 2101 South Oak Park Avenue, Berwyn, Illinois 60402. Damascus (Syria) 1972. Group or solo. Available July 1979.

Wen-I Lin, M.D., 5917 Culzean Drive, Apt. 505, Dayton, Ohio. Kaohsiung (Taiwan) 1968. Group or partnership. Available July 1979.

LETTERS TO THE JOURNAL

Comments Re SNJHSA

August 17, 1978

Dear Dr. Krosnick:

Your editorial* and recommendations regarding the Health Systems Agency (HSA) is the best that we have encountered and supports our findings based on years of membership on the previous Comprehensive Health Planning Board, now replaced by HSA. Your editorial should be mandated reading by all physicians, reproduced in all state medical society journals, as well as implemented by the medical societies throughout the country.

HSA is a private organization and has already placed its mark on the practice of medicine. It will affect, as you have pointed out, the practice of all physicians and does not necessarily provide better medical care.

Encouragement of volunteers, or paid observers to the HSA Board, may not be sufficient since, upon reviewing the By-Laws of the Southern New Jersey Health Systems Agency (SNJHSA), we find that there are legal loop-holes under which dissipation of huge federal grants is permissible.

Our experience in Cumberland County shows that the By-Laws under which the SNJHSA operates (Public Law 93-641) legally permit:

1. Conflicts of interest.
2. The SNJHSA Board members have received federal grants ranging from several hundred thousand dollars to over a million dollars. But best of all, "jobs and money for life." Under the By-Laws, SNJHSA Board members can apply for grants and remain in the room during their discussion and voting by the other members of the Board. This promotes retaliation or approval of subsequent applications by other fellow Board members.

3. Mandates specific Board members. The By-Laws specifically provide for members of HMO, PSRO, VA, and medical schools (all receiving federal and/or state funds) to be members of the Board of the SNJHSA. Since all are recipients of money, the By-Laws pro-

mote the possibility of "self interest" to become "conflicts of interest." This is especially true since HMO/PSRO's are private organizations.

4. Liability and Indemnification protection of the SNJHSA Board members. The liability coverage should be extended to the public who appears before the Boards with specific requests for a review of specific projects. This, in our case, involved a two million dollar federal grant for an alcoholic center (a very commendable project) but with a patients' census of eleven. All patients are required to pay \$50 a day for their care. Since this exposure, the project has been dropped for federal funding. Therefore, it is important to extend protection against possible lawsuit in the same manner that the members of the Board are protected by the By-Laws.

5. The SNJHSA Advocate (now called) "Health Planner," funded by SNJHSA and by each of the legislative bodies in the seven counties, may turn out to be a "Big Brother" program with high political clout since approval for certificate of needs, federal grants, and other matters coming before the Board creates jobs and money (taxpayers) and not necessarily "better medical care through better medical planning." (HSA slogan) In our county, one of seven in the area, over eight million dollars of projects were reviewed in one year! (Multiply this by seven times the remaining number of counties will quickly reveal the huge amount of money for funds and projects that is reviewed by the HSA).

It is therefore, recommended that the committees of the medical societies in each of the HSA areas of our state obtain the following under the Sunshine Law:

1. The By-Laws of the local HSA.
2. A copy of applications for grants and certificate of needs prior to and following Board action. This often provides a clue for trends and direction of medical care.
3. The names of projects and sponsors.
4. A list of HSA Board members who

under legal umbrellas obtain grants.

5. Report projects that do not promote better patient care, but self interest.

The SNJHSA came to Vineland with a 522 page (8 x 11-1/2) "draft" for approval of a 1.6 million dollar grant for funding. No one in the audience (attended by the public) acknowledged reading the grants which were available 19 days prior to the meeting. The draft was preceded by press releases in Cumberland County utilizing scare tactics such as: "high infant mortality rate"; "high venereal disease rate"; "high degree of cancer"; "suicides"; "cardiovascular disease"; and others. Particular attention was given to "physician shortages." It is also to be noted, that to create this "shortage" 761 physicians in Camden County were left out of the projects to establish shortages in order to apply for an HMO grant. In another case, the migrant farm workers were reported to be higher than were acknowledged by county officials. The scare tactic method has been utilized by other counties in other states. It is also to be noted that exposure of the shortcomings of the HSA and answering some of the static have resulted in corrections, but unfortunately at a much later time.

As physicians, we can no longer set ourselves apart from medical care of our citizens. We also must be alert to the expenditure of tax dollars unnecessarily.

In all fairness to HEW we have had excellent response from the New York office who sent down Mr. Frank DiGiovanni, field investigator to conduct a meeting with the SNJHSA. As yet, we have received no replies to our letters of April, 1978 and therefore must resort to further methods to attempt to replace some of the shortcomings we have encountered. Your suggestion of creating a central agency to receive such complaints would make this task much easier.

You have opened a "can of worms" worthwhile looking into correcting. Good luck!

(signed) Marvin N. Solomon, M.D.

*JMSNJ 75:513-514

Against ICME

August 18, 1978

Dear Doctor Krosnick:

I would like to respond to your editorial "Continuing Medical Education (C.M.E.)," in the August 1978 issue of *The Journal* of the Medical Society of New Jersey.

I agree with most of your comments concerning existing difficulties in continuing medical education, including the fact that there seem to be too many programs, too many sponsors, and that the fees are often too high. I agree with the desirability of *needs' assessment*. I especially agree that physicians must be in a position to determine their own needs, to plan programs for these needs.

I specifically do not agree, however, with the suggestion that we form in New Jersey an "Institute for Continuing Medical Education (I.C.M.E.)," to be sponsored by multiple organizations including the New Jersey State Departments of Health and Higher Education.

We in New Jersey are fortunate to have an organization already working toward the goals you outlined: The Academy of Medicine of New Jersey. For programs originating in our State, the Academy of Medicine has been extraordinarily responsive to the practicing physician, has given direction to the planning of programs, and the fees are very low or non-existent for some meetings.

A recent study¹ has indicated that the medical profession has lost control of most forms of medical education in this country, and that (graduate) medical education "is responding more to the dictates of the Congress, the Office of Management and Budget, and the Secretary of the Department of Health, Education, and Welfare (D.H.E.W.) than to the profession's leadership." We should not allow this to occur in the field of *continuing* medical education in New Jersey.

The Academy of Medicine of New Jersey always has been an apolitical organization, directed by its physician-members, and supported in part by the Medical Society of New Jersey, for which it is the educational arm. The Academy of Medicine can continue to serve this function. I feel strongly that if the State Departments of Health and

Higher Education became directly involved, our needs would become secondary to theirs.

In its ongoing efforts toward the goals outlined in the editorial, the Academy of Medicine is indeed looking for new and better ways to determine the needs of its members, and of studying new teaching techniques and other methods to maintain the quality of continuing medical education programs in the State of New Jersey. In these efforts, the Academy has provided for direct physician input at all levels.

The goals outlined in your editorial can best be realized by our continued support of our Academy of Medicine.

(signed) Paul J. Hirsch, M.D.

ICME: A Potential Solution

August 23, 1978

Dear Dr. Krosnick:

I think that your editorial in the August issue of *The Journal* is a masterful and scholarly one. It certainly touches upon all the problems of continuing medical education and presents a solution that if properly implemented has a chance of fulfilling the goals that we seek.

As I said in the article² which was published in the September issue of *The Journal*, the mini-residency and the sabbatical with hospital involvement in the role of a resident (which really amounts to a mini-residency) are the best ways really to meet the needs of continuing medical education.

I would refer you to an editorial in *S.G.O.* 145:417, September 1977, by Dr. Gerrish and an article in *JAMA* 239:2663, 1978, by Doctors Stross and Harlan which addressed the same problem.

The only people who are smug about the whole problem are the specialty boards who are convinced that recertification is the answer to the whole problem. I am most violently opposed to recertification by examination and relicensure by examination because I do not believe that these are even a miniscule of value in continuing medical education. If you will reread my article you will note that I too am unhappy with all of our present methods except for the sabbatical year and the mini-residency. I must repeat myself and say that you have done a masterful job of putting your finger on the weaknesses

inherent in our present system.

Your suggestion is one to be seriously considered. Therefore, I will take this up at the next meeting of the Committee on Medical Education so that we seriously can consider your suggestions and then act upon them.

As always it is a pleasure to read your well-thought-out, well-documented and well-expressed editorials in *The Journal*. I only hope that everyone reads them and takes them as seriously as I do so that we may make some forward progress in the morass of charges, counter charges, attacks, counter attacks, and federal and local invasion of our prerogatives.

Wishing you continued success and a long stewardship in your role as editor of *The Journal*.

(signed) Arthur Bernstein, M.D.

Unfortunate Anxiety over Ultrasound

August 29, 1978

Dear Editor:

I am writing to allay any fear concerning the potential danger or possible hazards of diagnostic ultrasound in medicine. This unfortunate anxiety presumably has been aroused by FDA Commissioner Donald Kennedy's news release a couple of months ago questioning the safety of "fetal monitoring" by diagnostic sonography. On the contrary, it should be pointed out that this technique has an unusually excellent safety record in that not one report of human damage or fetal abnormalities has occurred. The excitement and advantage of ultrasonic imaging lies in its ability to detect structures and their abnormalities in a non-invasive fashion. Without using ionizing radiation, the hazards of x-ray are eliminated.

The technique in medicine dates back about twenty-five years and its applications have been accepted widely throughout all scientific communities. Its use in obstetrics has been a breakthrough of great magnitude and has become the choice method of evaluating for placenta problems, multiparity, threatened or missed abortions, fetal age, fetal anomalies, and guidance for accurate and safe amniocentesis. Because of this, a few years ago, the American College of Obstetrics and Gynecology issued a statement mandating its availability for the high-risk obstetric patient population.

¹Edwards C C: Has the medical profession lost control of medical education? *JAMA* 239:2463-2465, 1978.

²Coping with medical obsolescence. *JMSNJ* 75:678:680 (Sept. 1978).

The Biological Effects Committee of the American Institute of Ultrasound in Medicine headed by Professor Wesley L. Nyborg had issued a statement on the safety of diagnostic ultrasound in August of 1976 and has reiterated the same in May of 1978. It states that "in the low megahertz frequency range (0.5 to 10

MHZ) there have been (as of this date) no demonstrated significant biological effects in mammalian tissues . . . It should be noted that this statement applies to all known data on biological changes produced in mammalian tissues by ultrasound in the frequencies clinically in use. In a recent communication Dr.

Nyborg has commented, in regard to the FDA news release, that "it is a pity that needless anxieties are aroused."
In conclusion the non-utilization of this invaluable modality for unfounded reasons will cause the practice of medicine to regress two decades.
(signed) Ira Berger, M.D.

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May 12-15, 1979

	DAILY RATES		
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Holiday Inn	\$42	\$46	Rates quoted upon request
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	58	62	

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PERSONAL ITEM

Dr. Heinz Lippmann Honored

Heinz I. Lippmann, M.D., a member of our Bergen County component, was honored recently by the State of New Jersey on the occasion of his 70th birthday on May 21. On May 22 the Senate of the State of New Jersey adopted the following resolution in recognition of his contribution to medicine and mankind:

Whereas, Heinz Israel Lippmann, M.D., celebrated his 70th birthday on May 21st; and,

Whereas, he has devoted his life to the benefit of mankind as a physician; and,

Whereas, he has also served as a professor of biochemistry, physiology, and rehabilitative medicine in major universities in the United States and Europe; and,

Whereas, he has made numerous contributions to scholarly medical journals; and,

Whereas, as a distinguished concert pianist he has given concerts every year since 1933 including performing as a soloist with the New York Philharmonic on two occasions; now, therefore be it

RESOLVED by the Senate of the State of New Jersey: that this House congratulates Dr. Heinz Israel Lippmann upon his 70th birthday and extends best wishes for success

in his future endeavors; and be it further

RESOLVED, that a duly authenticated copy of this resolution, signed by the President, and attested to by the Secretary, be transmitted to Dr. Heinz Israel Lippmann.

Dr. Lippmann is Director of Rehabilitation at Jewish Hospital and Rehabilitation Center, Jersey City and at Barnert Memorial Hospital, Paterson, and Chief of Peripheral Vascular Diseases and Emeritus Professor of Medicine at Albert Einstein College of Medicine in the Bronx.

CME INFORMATION

Basic Sciences and Clinical Application

The Burlington County Memorial Hospital in Mount Holly has announced the following program in its series on basic sciences and clinical application. Sessions convene Thursdays at 3:30 p.m. on the dates indicated, in the conference center of the hospital. Each lecture meets the criteria for one credit hour in Category I of the AMA Physician's Recognition Award. For information please communicate with Dr. Robert W. Parvin, Director of Medical Education at the hospital, 175 Madison Avenue, Mount Holly 08060.

- Oct. 12 Acute Abdomen
- Oct. 19 Lessons from Mistakes
- Oct. 26 Viral Hepatitis
- Nov. 2 Depressed Cardiac Patient
- Nov. 9 Headaches
- Nov. 16 Shock and Its Complications
- Nov. 30 Potassium Imbalance
- Dec. 7 Hyperlipidemia
- Dec. 14 "Small" Infections
- Dec. 21 Senile Cataract

Sports Medicine Series

The Orthopedic Section, Division of Sports Medicine, New Jersey Medical School, CMDNJ, has announced the following Distinguished Guest Lecturer Series in Sports Medicine. The first program—on football injuries—was held on September 7. Additional scheduling is as follows:

- October 19—Head Injuries in Contact Sports
- November 9—Life Clinic—Fitness and Exercise
- November 16—Medical Aspects of Soccer
- December 7—Writing Your Clinical Paper

Lectures will be held at 7 p.m. in Room B-610 of the Medical Science Building, 100 Bergen Street, Newark. Following each presentation there will be a half-hour question and answer period. There is no fee. For information please communicate with Mrs. Anne Stephans at the College—(201) 456-5350.

VA Medical Grand Rounds

The following program has been announced by the Pulmonary Disease Section of the Veterans Administration Hospital in East Orange. Sessions are held on Wednesdays on the dates indicated at 11:30 a.m. in the third floor amphitheatre of the hospital. The first program, "Diagnostic Techniques in Pulmonary Diseases," was held on September 20.

- October 25—Respiratory Control: Norman H. Edelman, M.D., CMDNJ-Rutgers Medical School
- November 29—Pharmacology and Treatment of Bronchial Asthma: Carl B. Sherter, M.D., Yale University School of Medicine
- December 20—Tracheobronchial Tree in Relation to Environmental Hazards: Oscar Auerbach, M.D., VA Hospital, East Orange
- April 18—Thromboembolic Disease: Sol Sherry, M.D., Temple University School of Medicine
- May 23—Interstitial Pulmonary Disease: Edward A. Gaensler, M.D., Boston University School of Medicine

For information please communicate with L. Fred Ayzazian, M.D., Chief, Pulmonary Section, Veterans Administration Hospital, East Orange 07019.

Conference on Adult Diabetes

A two-day conference on the management of adult diabetes, October 25 and 26, will be held at the Pikesville Hilton, Baltimore, under the sponsorship of the Maryland Affiliate of the American Diabetes Association. Objectives of the meeting are update of current research findings, both pathophysiological and educational with the goal of more effective management, education, and compliance of the non-acute patient. Faculty will include diabetologists from the University of Rochester, the University of Pennsylvania and Johns Hopkins Medical Institutes. For information please communicate with Ms. Linda Warren, Health and Education Council, 7201 Rossville Blvd., Baltimore 21237 (301) 686-3610.

Seminar on Head and Neck Tumors

The Sixth W. Franklin Keim Memorial Seminar on head and neck tumors will be held November 9 through 11 at the New Jersey Medical School in Newark under the sponsorship of the school and the Newark Eye and Ear Infirmary. Some of the topics to be considered are tumor immunology, pathology of head and neck tumors, radiotherapy, surgery, and rehabilitation. Question and answer periods will be held after each presentation, and there will be group discussions at the luncheon tables. Tuition is \$150 for practicing physicians and \$50 for residents. The program is approved for 18 hours in Category I of the AMA Physician's Recognition Award. For further information please communicate with Dr. Ki Y. Han, Newark Eye Infirmary, 15 South 9th Street, Newark 07107.

Ambulation and Mentation

On November 12, from 9 a.m. to 4 p.m., a CME course, "Ambulation and Mentation," will be presented at the Cherry Hill Hyatt House under the auspices of the AMA Council on Continuing Physician Education. The program, under the direction of David Eckstein, M.D., is designed for those treating the elderly. There are two major areas of consideration: changes in mentation,

and degenerative and traumatic joint diseases. The session will be devoted to discussion of the etiology, differential diagnosis, and management of senile dementia, and to surgical repair of the aged and traumatized hip and knee. Six credits will be given in Category I of the AMA CME Award. Cost is \$70 which includes breakfast and luncheon. For further information please contact Dr. Eckstein, Meadow Lakes, P.O. Box 70, Hightstown 08520—(609) 448-4100.

Symposium on Battering Family Members

On November 15, at the Holiday Inn, North Brunswick, an all-day symposium, "Battering Family Members: Our Explosive Society," will be held under the sponsorship of the New Jersey Public Health Association. Credit will be given in AMA Category I; the fee is \$8 for members and \$10 for others, including luncheon. Topics listed are "Psycho-Social Factors Underlying Aggression," "Child-Adult Rape Victims and Incest," "Battered Spouses in the Emergency Room," "A Judge's Perspective of Battered Families," "Children of Battered Families," "A Battered Woman," and "Perils in the Classroom." Advance registration should be made to NJPHA, Box 529, East Brunswick 08816. For details on the program communicate with Dr. Sylvia Herz, 220 Tillou Road, South Orange 07079—(201) 763-3662.

EENT Seminar

On November 15, at the "Town and Campus" in West Orange, the New Jersey Academy of Ophthalmology and Otolaryngology will hold an all-day meeting on "Multidisciplinary Management of Oral-Facial Pain." Topics include: "Neurologist's Approach to Facial Pain," "Radiological Diagnosis of Facial Pain," "Oral Orthopedics," "Otomandibular Syndrome," and "Theory and Practical Use of Accupuncture for Facial Pain." For nonmembers of the Academy the fee is \$50 and \$25 for residents and allied personnel. The Program has been approved for 6 credits in Category I of the AMA Physician's Recognition Award. For further information please communicate with the Academy, c/o Eye Institute of New Jersey, 15 South Ninth Street, Newark 07107.

CME Courses in Florida

The University of Miami School of Medicine has announced two graduate courses for practicing physicians. One, "Neurological Update," will be held from January 29 to February 2, 1979, in Miami Beach. CME credits will be awarded. The other, a symposium on surgical intensive care, also held in Miami Beach, will convene from May 4 to 7. Twenty CME credit hours will be granted for the latter. For details on both of the programs please communicate with the Division of Continuing Medical Education D-23-3, University of Miami School of Medicine, P.O. Box 016960, Miami, Florida 33101.

Pediatric Dermatology Seminar

From February 17 to 25, 1979, the Sixth Annual Pediatric Dermatology Seminar will be held aboard the *Bucaneer* while cruising the Galapagos Islands. Tuition is \$150 and the cost of the cruise, which departs from Miami, is \$1290 per person, double occupancy. For information please communicate with Guinter Kahn, M.D., 16800 N.W. Second Avenue, North Miami Beach, Florida 33169.

Radiology Course

From April 2 to 6, 1979, a tutorial course on radiology of the chest will be offered by the Department of Radiology, Duke University Medical Center, Durham. Emphasis will be on personalized tutorial type teaching, using original roentgenograms and slide material, with ample time for discussion. The subject matter will cover all facets of chest disease and diagnostic techniques. An abstract book with references will be provided. Thirty credit hours will be given in Category I of the AMA Physician's Recognition Award. Inquiries should be directed to Robert McLelland, M.D., Radiology—Box 3808, Duke University Medical Center, Durham, NC 27701—(919) 684-4397.

Correction

The Journal calls attention to an error on page 534 of the July 1978 issue—"Complex Gastrointestinal Fistulae" by Ralph S. Greco, M.D. The legends for figures 1 and 2 are reversed. The illustration in the right-hand column is figure 1; figure 2 is the illustration in the left-hand column.

CME CALENDAR

This listing is compiled through the cooperation of the Committee on Medical Education of the Medical Society of New Jersey, the Academy of Medicine of New Jersey, the New Jersey Chapter of the American Academy of Family Physicians, and the Office of Continuing Medical Education of the College of Medicine and Dentistry of New Jersey. For information on accreditation, please contact the sponsoring organization(s), indicated by italics—last line of each item.

Oct.

- 11 **Endocrine Conferences**
- 18 3:30-5 p.m.—Rotating between Newark
- 25 Beth Israel Medical Center, Martland, and East Orange VA Hospitals (*AMNJ*)
- 11 **Medical Aspects of Psychosomatic Illness—Part III**
- 25 **Family Therapy—Part I**
3:15-4:15 p.m.—Fair Oaks Hospital, Summit (*Fair Oaks Hospital and AMNJ*)
- 11 **Alcoholism**
1:30-2:30 p.m.—John E. Runnells Hospital, Berkeley Heights (*John E. Runnells Hospital and AMNJ*)
- 11 **Continuing Education in Psychiatry**
1-3 p.m.—Bergen Pines County Hospital (*Bergen Pines Hospital and AMNJ*)
- 25 **Clinical Pathology Grand Rounds**
12 noon-1 p.m.—New Jersey Medical School, Newark (*CMDNJ and AMNJ*)
- 11 **Grand Rounds and Case Presentations**
18 2-4 p.m.—Rotating between Martland,
- 25 Newark Beth Israel, St. Michael's, St. Joseph's Hospitals and Jersey City Medical Centers (*CMDNJ and AMNJ*)
- 11 **Recurrent Urinary Tract Infections in Older Patients**
- 18 **Treatment of Uremia**
- 25 **Radiology-Pathology Conference**
11:30 a.m.-1:30 p.m.—Rahway Hospital (*Rahway Hospital and AAFP*)
- 11 **Death and Dying**
18 7-9 p.m.—St. Joseph's Hospital and
- 25 Medical Center, Paterson (*Passaic Valley Hospital Social Service Association and AMNJ*)
- 11 **Course for Psychiatrists—Semester I**
18 8-10 p.m.—Hackensack Hospital
- 25 (*NJ Psychoanalytic Society and AMNJ*)
- 12 **Virology**
19 4-6 p.m.—Institute for Medical
- 26 Research, Copewood St., Camden (*Institute for Medical Research and AMNJ*)
- 12 **Neurosurgical Case Presentations**
19 4-5:30 p.m.—NJ Medical School,
- 26 Newark (*CMDNJ and AMNJ*)
- 12 **Diabetes Update**
- 19 **Disease of the Adrenal Gland**
- 26 **Thyroid Disease**
11:45 a.m.-12:45 p.m.—John F. Kennedy Medical Center, Edison (*John F. Kennedy Medical Center*)
- 12 **Care for the Spinal Cord Injured**
1-3 p.m.—VA Hospital, East Orange (*VA Hospital and AMNJ*)
- 12 **Women's Fear of Being Fat**
8:30-10:30 p.m.—Hackensack Hospital (*New Jersey Psychoanalytic Society and AMNJ*)
- 12 **Case Presentations and Guest Speakers**
7:30-9:30 p.m.—Location to be announced (*New Jersey Institute of Ultrasound in Medicine and AMNJ*)
- 12 **Cardiology Conferences**
19 2:15-4:15 p.m.—Deborah Heart and
- 26 Lung Center, Browns Mills (*Deborah Heart and Lung Center and AMNJ*)
- 12 **Psychiatric Lecture Series**
19 11 a.m.-12 noon—Greystone Park
- 26 Psychiatric Hospital (*Greystone Park Psychiatric Hospital and AMNJ*)
- 12 **Grand Rounds and Case Presentations**
19 4-5 p.m.—Martland Hospital, Newark
- 26 (*CMDNJ and AMNJ*)
- 13 **Diagnostic and Therapeutic Problems in Orthopedics**
17 7:30-9 a.m.—Alexian Brothers Hospital, Elizabeth (*Alexian Brothers Hospital*)
- 13 **Psychiatric Lecture Series**
20 1:30-5 p.m.—Trenton Psychiatric
- 27 Hospital (*Trenton Psychiatric Hospital and AMNJ*)
- 13 **Advances in Pediatrics**
20 9:30-10:30 a.m.—Medical Sciences
- 27 Bldg., NJ Medical School, Newark (*CMDNJ-NJ Medical School Dept. of Pediatrics and AMNJ*)
- 14 **Ophthalmology for the Non-Ophthalmologist**
9 a.m.-5 p.m.—United Hospitals
- Medical Center, Newark (*United Hospitals Medical Center and AMNJ*)
- 14 **Learning Disabilities**
9:30 a.m.-1 p.m.—St. Barnabas Medical
- Center, Livingston (*NJ Orton Society and AMNJ*)
- 16 **Neuroscience Conferences**
23 11:30 a.m.-12:30 p.m.—Bergen Pines
- 30 County Hospital, Paramus (*Bergen Pines County Hospital and AMNJ*)
- 16 **Lecture Series in Surgery**
23 4:30-5:30 p.m.—NJ Medical School,
- 30 Newark (*CMDNJ and AMNJ*)
- 16 **Sexually Transmitted Diseases**
8-9 p.m.—Mountainside Hospital, Montclair (*Mountainside Family Practice Associates and AMNJ*)
- 17 **Systemic Lupus Arrhythmias**
8-9 a.m.—Greater Paterson General Hospital, Wayne (*Greater Paterson General Hospital and AMNJ*)
- 17 **Interpretation of Pulmonary Function Studies**
8-9 a.m.—Garden State Community Hospital, Marlton (*Garden State Community Hospital and AMNJ*)
- 17 **Seminar on Law and Psychiatry**
24 3:30-5:30 p.m.—Rutgers Law School,
- 31 Newark (*Rutgers University Law School and AMNJ*)
- 17 **Congestive Heart Failure**
- 24 **Coronary Artery Disease**
11 a.m.-12 noon—Greystone Park Psychiatric Hospital (*Greystone Park Psychiatric Hospital and AMNJ*)
- 17 **Current Chemotherapy**
7-8 p.m.—Irvington General Hospital (*Irvington General Hospital and AMNJ*)
- 17 **Laboratory Interpretations**
11:30 a.m.-12:30 p.m.—St. Mary's Hospital, Orange (*St. Mary's Hospital and AMNJ*)
- 17 **Medical Genetics**
2-3 p.m.—Ancora Psychiatric Hospital, Hammonton (*Ancora Psychiatric Hospital and AMNJ*)
- 18 **Emergency Medical Care**
1-2 p.m.—Trenton Psychiatric Hospital (*Trenton Psychiatric Hospital and AMNJ*)
- 18 **Heart Attack Prevention Through Counseling**
9 a.m.-5 p.m.—Howard Johnson's, Newark (*CMDNJ, AAFP, and AMNJ*)
- 18 **Sexual Dysfunction**
1-3 p.m.—Ancora Psychiatric Hospital, Hammonton (*Ancora Psychiatric Hospital and AMNJ*)
- 18 **Advances in Medicine**
25 9:30-11 a.m.—Bergen Pines County Hospital, Paramus (*Bergen Pines County Hospital and AMNJ*)
- 18 **Granulomatous Diseases of the Bowel**
- 25 **Cryosurgery**
1-3 p.m.—Christ Hospital, Jersey City (*Christ Hospital, AMNJ, and AAFP*)
- 18 **Masks of Depression**
- 25 **Sarcoidosis and other Granulomatous Disorders**
9-11 a.m.—Middlesex General Hospital,

- New Brunswick
(*Middlesex General Hospital, AMNJ, and AAFP*)
- 18 **Ophthalmologic Lecture**
7:15-9:30 p.m.—United Hospitals Medical Center, Newark
(*Associated Eye Residencies of NJ and AMNJ*)
- 18 **Difficult Diagnoses in Rheumatology**
9-3 p.m.—Rutgers Medical School, Piscataway
(*The Arthritis Foundation, NJ Chapter, NJ Rheumatism Association, and AMNJ*)
- 18 **Hypertension**
- 25 **Septic Shock**
9-11 a.m.—Riverview Hospital, Red Bank
(*Riverview Hospital and AMNJ*)
- 19 **Update—Nuclear Cardiology**
5-6:30 p.m.—Somerset Hospital, Somerville
(*Somerset Hospital and AMNJ*)
- 19 **Gene Expression in Biomedical Research**
1:45-5:30 p.m.—Drew University, Madison
(*Drew University, CIBA-GEIGY and AMNJ*)
- 19 **Head Injuries in Contact Sports**
7-8:30 p.m.—NJ Medical School, Newark
(*CMDNJ and AMNJ*)
- 19 **Double Contrast Examination of the Upper GI Tract**
7:15-10:15 p.m.—Hospital Center at Orange
(*Diagnostic Radiology Section for Northern New Jersey and AMNJ*)
- 20 **Recent Advances in Perinatology**
8:15-10:30 a.m.—Overlook Hospital, Summit
(*Overlook Hospital and AMNJ*)
- 20 **Psychiatry and the Law**
8-10 p.m.—Mayfair Farms, West Orange
(*NJ Psychiatric Association and AMNJ*)
- 20 **Forensic Psychiatry**
- 25 **Electroconvulsive Therapy**
1:30-3 p.m.—NJ Medical School, Newark
(*CMDNJ and AMNJ*)
- 21 **Advances in Medical Diagnosis Imaging**
Hilton Inn, Eatontown
(*Jersey Shore Medical Center and AMNJ*)
- 24 **Drug Interactions**
8-10 p.m.—The Englewood Club
(*Englewood Surgical Society and AMNJ*)
- 25 **Neuropathology Conferences**
8-9:15 a.m.—New Jersey Medical School, Newark
(*CMDNJ and AMNJ*)
- 25 **Cardiac Grand Rounds**
3-4:30 p.m.—CMDNJ-NJ Medical School, Newark
(*American Heart Association, NJ Affiliate, and AMNJ*)
- 25 **Respiratory Control**
11:30 a.m.-1 p.m.—VA Hospital, East Orange
(*VA Hospital and AMNJ*)
- 25 **Total Parenteral Nutrition**
9:30-11:30 a.m.—Dover General Hospital
(*Riverside, Dover General, St. Claire's Hospitals and AMNJ*)
- 25 **Blood Components and Their Indications**
1-3 p.m.—VA Hospital, Lyons
(*VA Hospital and AMNJ*)
- 26 **Clinical Pathology Conference**
8-9 p.m.—John E. Runnells Hospital, Berkeley Heights
(*John E. Runnells Hospital and AMNJ*)
- 26 **Advances in Antibiotics and Viral Chemotherapy**
12 noon-1 p.m.—Carrier Foundation, Belle Mead
(*The Carrier Foundation*)
- 30 **Issues in Police Psychiatry**
10 a.m.-4 p.m.—St. Michael's Medical Center, Newark
(*The Psychiatric Institute and AMNJ*)
- 31 **Effect of Changing Sex Roles in Marriage**
8-10 p.m.—Mayfair Farms Restaurant, West Orange
(*TriCounty Chapter, NJ Psychiatric Association, and AMNJ*)
- 31 **Gastrointestinal Disorders in Children**
8-9 a.m.—Greater Paterson General Hospital, Wayne
(*Greater Paterson General Hospital and AMNJ*)
- Nov.
- 1 **Continuing Education in Psychiatry**
- 8 1-3 p.m.—Bergen Pines County Hospital
- 15 Paramus
- 22 (*Bergen Pines Hospital and AMNJ*)
- 1 **Emergency Care: Medical**
1-3 p.m.—Christ Hospital, Jersey City
(*Christ Hospital and AMNJ*)
- 1 **Lectures in Obstetrics and Gynecology**
8-10 p.m.—Location varies
(*CMDNJ and AMNJ*)
- 1 **Diagnosis of Anemic Patient**
- 29 **Clinical Immunology**
10:30 a.m.-12 noon—St. Mary's Hospital, Passaic
(*St. Mary's Hospital and AMNJ*)
- 1 **Sexual Dysfunction-Case Histories**
- 15 **Sexual Dysfunction-Research**
- 29 **Psychiatric Emergencies**
1-3 p.m.—Ancora Psychiatric Hospital
(*Ancora Psychiatric Hospital and AMNJ*)
- 1 **Hypertension**
- 8 **CEA Program**
- 15 **Chemotherapy of Breast Tumors**
- 22 **Chartmanship**
- 29 **Radiology-Pathology Conference**
11:30 a.m.-1:30 p.m.—Rahway Hospital
(*Rahway Hospital and AAFP*)
- 1 **Grand Rounds and Case Presentations**
- 8 2-4 p.m.—Rotating between Martland, Newark Beth Israel, St. Michael's, St.
- 15 Joseph's Hospital and Jersey City
- 22 Medical Center
- 29 (*CMDNJ and AMNJ*)
- 1 **Clinical Pathology Grand Rounds**
- 8 12 noon-1 p.m.—New Jersey Medical
- 15 School, Newark
- 22 (*CMDNJ and AMNJ*)
- 29
- 1 **Spectrum of Arthritis**
- 8 **Selection of Therapy for Aortic Valve Disease**
- 15 **Aerobic Infections**
- 22 **Some Areas of Controversy in Cardiology**
- 29 **Drug-Induced Psychoses**
9-11 a.m.—Middlesex General Hospital, New Brunswick
(*Middlesex General Hospital, AMNJ and AAFP*)
- 1 **Medical Grand Rounds**
11:30 a.m.—Rotates between Newark Beth Israel Medical Center, Martland, and East Orange VA Hospitals
(*AMNJ*)
- 1 **Hypertension Update**
1:45-5:45 p.m.—Rutgers Medical School, Piscataway
(*CMDNJ and AMNJ*)
- 1 **Endocrinology—Dinner Meeting**
6:30-9:30 p.m.—Holiday Inn, East Orange
(*AMNJ Endocrinology Section*)
- 1 **Advances in Medicine**
- 8 9:30-11 a.m.—Bergen Pines County
- 15 Hospital
- 22 (*Bergen Pines County Hospital and*
- 29 *AMNJ*)
- 1 **Course for Psychiatrists—Semester I**
- 8 8-10 p.m.—Hackensack Hospital
- 15 (*NJ Psychoanalytic Society and AMNJ*)
- 1 **Transfusion Reactions in Clinical Practice**
1-3 p.m.—VA Hospital, Lyons
(*VA Hospital and AMNJ*)
- 1 **Chronic Obstructive Pulmonary Disease**
- 8 **Pediatrics Pharmacology**
- 15 **Occupational Hazards of Being a Physician**
- 22 **Lipids**
- 29 **Malabsorption**
9-11 a.m.—Riverview Hospital, Red Bank
(*Riverview Hospital and AMNJ*)
- 1 **Emergency Care: Medical**
- 8 **Occupational Lung Disease**
- 15 **Common Venereal Disease**
- 29 **Total Parenteral Nutrition**
1-3 p.m.—Christ Hospital, Jersey City
(*Christ Hospital, AMNJ and AAFP*)
- 2 **Psychotherapeutic Techniques**
8-10 p.m.—312 Harding Drive, South Orange
(*Group for Advanced Psychiatric Study and AMNJ*)
- 2 **Cardiology Conferences**
- 9 2:15-4:15 p.m.—Deborah Heart and
- 16 Lung Center, Browns Mills
- 30 (*Deborah Heart and Lung Center and AMNJ*)
- 2 **Education in Human Sexuality**
- 9 **Conceptual Problems in Diagnosis**
12 noon-1 p.m.—Carrier Foundation, Belle Mead
(*The Carrier Foundation*)
- 2 **Psychiatric Lecture Series**
- 9 11 a.m.-12 noon—Greystone Park
- 16 Psychiatric Hospital
- 30 (*Greystone Park Psychiatric Hospital and AMNJ*)
- 2 **Grand Rounds and Case Presentations**
- 9 4-5 p.m.—Martland Hospital, Newark
(*CMDNJ and AMNJ*)
- 16
- 30
- 2 **Esophageal Varices**
- 9 **Hepatitis Update**
- 14 **Amniocentesis**
- 16 **Gastric and Duodenal Ulcer Disease**
- 30 **Cirrhosis**
11:45 a.m.-12:45 p.m.—John F. Kennedy Medical Center, Edison
(*John F. Kennedy Medical Center*)
- 2 **Neurosurgical Case Presentations**
- 9 4-5:30 p.m.—New Jersey Medical
- 16 School, Newark
- 30 (*CMDNJ and AMNJ*)

- 2 **Virology**
9 4-6 p.m.—Institute for Medical
16 Research, Copewood St., Camden
30 (*Institute for Medical Research and
AMNJ*)
- 3 **Diagnostic and Therapeutic Problems in
10 Orthopedics**
24 7:30-9 a.m.—Alexian Brothers Hospital,
Elizabeth
(*Alexian Brothers Hospital*)
- 3 **Colitis**
8:30-9:30 a.m.—United Hospitals of
Newark
(*United Hospitals of Newark and AMNJ*)
- 3 **Psychiatric Lecture Series**
10 1:30-5 p.m.—Trenton Psychiatric
Hospital
(*Trenton Psychiatric Hospital and
AMNJ*)
- 3 **Advances in Pediatrics**
17 9:30-10:30 a.m.—NJ Medical School,
Newark
(*CMDNJ and AMNJ*)
- 4 **Critical Care Medicine**
9 a.m.-1 p.m.—North Jersey Country
Club, 584 Hamburg Turnpike, Wayne
(*Paterson General Hospital and AMNJ*)
- 6 **Lecture Series in Surgery**
13 4:30-5:30 p.m.—NJ Medical School,
20 Newark
27 (*CMDNJ and AMNJ*)
- 6 **Psychiatric Lecture Series**
8-10 p.m.—4 Garden Place, Nutley
(*Essex Psychiatric Seminar and AMNJ*)
- 6 **Neuroscience Conference**
13 11:30 a.m.-12:30 p.m.—Bergen Pines
20 County Hospital, Paramus
27 (*Bergen Pines County Hospital and
AMNJ*)
- 7 **Seminar on Law and Psychiatry**
14 3:30-5:30 p.m.—Rutgers Law School,
21 Newark
(*Rutgers University Law School and
AMNJ*)
- 7 **Lecture Series in Otolaryngology**
8-9 p.m.—Garden State Community
Hospital, Marlton
(*Garden State Community Hospital and
AMNJ*)
- 7 **An In-Depth View of the Vagus**
5-6 p.m.—Rutgers Medical School,
Piscataway
(*CMDNJ and AMNJ*)
- 7 **Gram Negative Sepsis**
8-9 a.m.—Greater Paterson General
Hospital, Wayne
(*Greater Paterson General Hospital and
AMNJ*)
- 8 **Cancer of the Pancreas**
29 **The Pneumonias**
9:30-11:30 a.m.—Dover General
Hospital
(*Riverside, Dover General, St. Clare's
Hospitals and AMNJ*)
- 8 **Endorphins and Enkephalons in
Psychiatry and Medicine**
29 **Liaison Psychiatry**
1:30-3 p.m.—NJ Medical School,
Newark
(*CMDNJ and AMNJ*)
- 8 **Family Therapy—Part II**
22 **Family Therapy—Part III**
3:15-4:15 p.m.—Fair Oaks Hospital,
Summit
(*Fair Oaks Hospital and AMNJ*)
- 8 **Drug Addiction**
1:30-2:30 p.m.—John E. Runnells
Hospital, Berkeley Heights
(*John E. Runnells Hospital and AMNJ*)
- 8 **Endocrine Conferences**
15 3:30-5 p.m.—Rotates between Newark
22 Beth Israel Medical Center, Martland,
29 and East Orange VA Hospitals
(*AMNJ*)
- 8 **Learning Disorders 1-5 p.m.**
Children of Divorce 8-9 p.m.—Ramada
Inn, Clark
(*NJ Chapter, AAP and AMNJ*)
- 9 **Outpatient Treatment of Burns**
8-9 p.m.—Zurbrugg Memorial Hospital,
Riverside
(*Burlington County Medical Society and
AMNJ*)
- 9 **Case Presentations and Guest Speakers**
7:30-9:30 p.m.—Location to be
announced
(*New Jersey Institute of Ultrasound in
Medicine and AMNJ*)
- 9 **Outpatient Treatment of Burns**
8-9 p.m.—Zurbrugg Memorial Hospital,
Riverside
(*Burlington County Medical Society and
AAFP*)
- 9 **Teaching Skills for Family Medicine
Preceptors**
8:30 a.m.—Rutgers Medical School,
Piscataway
(*CMDNJ and AAFP*)
- 9 **Life Clinic**
16 **Medical Aspects of Soccer**
7-8:30 p.m.—NJ Medical School,
Newark
(*CMDNJ and AMNJ*)
- 11 **Regional Meeting 9 a.m.**
12 **Office Gynecology 9 a.m.-4 p.m.**—
Cherry Hill Hyatt House
(*AMA Council on Continuing Physician
Education and AMNJ*)
- 12 **Amputation and Mentation**
9 a.m.-4 p.m.—Cherry Hill Hyatt House
(*AMA Council on Continuing Physician
Education*)
- 14 **Malpractice**
2-3 p.m.—Ancora Psychiatric Hospital,
Hammonton
(*Ancora Psychiatric Hospital and AMNJ*)
- 14 **Adrenal Diseases**
21 **Diabetes**
28 **Obesity**
11 a.m.-12 noon—Greystone Park
Psychiatric Hospital
(*Greystone Park Psychiatric Hospital and
AMNJ*)
- 14 **Treatment of the Severe Psoriatic**
8-10 p.m.—Schering Corporation,
Kenilworth
(*NJ Dermatological Society and AMNJ*)
- 14 **Pediatric Nuclear Medicine**
21 8-9 a.m.—Garden State Community
Hospital, Marlton
(*Garden State Community Hospital and
AMNJ*)
- 14 **Solid Tumor Chemotherapy**
28 **Hyperalimentation**
8 a.m.-9 a.m.—Greater Paterson
General Hospital, Wayne
(*Greater Paterson General Hospital and
AMNJ*)
- 15 **Diagnosis and Management of GIT
Bleeding**
1-2 p.m.—Trenton Psychiatric Hospital
(*Trenton Psychiatric Hospital and
AMNJ*)
- 15 **Recent Advances in Gastroenterology**
9 a.m.-5 p.m.—VA Hospital, East
Orange
(*VA Hospital and AMNJ*)
- 15 **Fall Refresher Seminar**
8:30 a.m.-4:45 p.m.—John F. Kennedy
Medical Center, Edison
(*New Jersey Chapter, AAFP, and AMNJ*)
- 16 **Annual George Gross Memorial Lecture:
Leukemia Treatment Today**
9:30 a.m.-12:30 p.m.—Newark Beth
Israel Medical Center
(*Newark Beth Israel Medical Center and
AMNJ*)
- 16 **CAT Scanning**
7:15-10:15 p.m.—Hospital Center at
Orange
(*Diagnostic Radiology Section for
Northern New Jersey and AMNJ*)
- 16 **Current Techniques in Ultrasound**
5-6:30 p.m.—Somerset Hospital,
Somerville
(*Somerset Hospital and AMNJ*)
- 17 **Recent Advances in Genetic Diagnosis and
Counseling**
8:15-10:30 a.m.—Overlook Hospital,
Summit
(*Overlook Hospital and AMNJ*)
- 18 **Medical Aspects of Wrestling**
9 a.m.-2 p.m.—United Hospitals
Medical Center, Newark
(*United Hospitals Orthopedic Center and
AMNJ*)
- 18 **Complications of Diabetes**
8 a.m.-1 p.m.—Rutgers Medical School,
Piscataway
(*American Diabetes Association, NJ
Affiliate, and AMNJ*)
- 20 **Immediate Mammoplast following Breast
Amputation**
7:45-9 a.m.—Newark Beth Israel
Medical Center
(*Newark Beth Israel Medical Center and
AMNJ*)
- 20 **Psychiatric Issues in Industrial Medicine**
9:30 a.m.-3:30 p.m.—The Psychiatric
Institute, 268 High St., Newark
(*The Psychiatric Institute and AMNJ*)
- 21 **Gastrointestinal Bleeding**
7-8 p.m.—Irvington General Hospital
(*Irvington General Hospital and AMNJ*)
- 21 **Current Chemotherapy**
11:30 a.m.-12:30 p.m.—St. Mary's
Hospital, Orange
(*St. Mary's Hospital and AMNJ*)
- 21 **Life and Transitions**
1-4:30 p.m.—Mercer County
Community College, Trenton
(*Mercer County Unit, American Cancer
Society and AMNJ*)
- 22 **Newer Concepts in Pediatric
Ophthalmology**
7:15-9:30 p.m.—United Hospitals
Medical Center, Newark
(*Associated Eye Residencies of NJ and
AMNJ*)
- 22 **Neuropathology Conferences**
8-9:15 a.m.—New Jersey Medical
School, Newark
(*CMDNJ and AMNJ*)
- 28 **Malignant Hyperthermia**
8-10 p.m.—The Englewood Club,

- Englewood
(*Englewood Surgical Society and AMNJ*)
- 29 **Cardiac Grand Rounds**
3-4:30 p.m.—NJ Medical School,
Newark
(*American Heart Association, NJ
Affiliate and AMNJ*)
- 29 **Bronchial Asthma**
11:30 a.m.-1 p.m.—VA Hospital, East
Orange
(*VA Hospital Pulmonary Disease Section
and AMNJ*)
- Dec.
- 1 **Proper Use of Antibiotics**
8:30-9:30 a.m.—United Hospitals of
Newark
(*United Hospitals of Newark and AMNJ*)
- 1 **Diagnostic and Therapeutic Problems in**
8 **Orthopedics**
22 7:30-9 a.m.—Alexian Brothers Hospital,
Elizabeth
(*Alexian Brothers Hospital*)
- 1 **Advances in Pediatrics**
8 9:30-10:30 a.m.—NJ Medical School,
15 Newark
22 (*CMDNJ and AMNJ*)
- 1 **Psychiatric Lecture Series**
1:30-5 p.m.—Trenton Psychiatric
Hospital
(*Trenton Psychiatric Hospital and
AMNJ*)
- 2 **27th Annual Clinical Meeting**
9 a.m.-4:15 p.m.—NJ Medical School,
Newark
(*NJ Chapter, American College of
Surgeons and AMNJ*)
- 4 **Neuroscience Conferences**
11 11:30 a.m.-12:30 p.m.—Bergen Pines
18 County Hospital, Paramus
(*Bergen Pines County Hospital and
AMNJ*)
- 4 **Psychiatric Lecture Series**
8-10 p.m.—192 Chittenden Rd., Clifton
(*Essex Psychiatric Seminar and AMNJ*)
- 4 **Lecture Series in Surgery**
11 4:30-5:30 p.m.—NJ Medical School,
18 Newark
25 (*CMDNJ and AMNJ*)
- 5 **Why Treat Diabetes?**
- 12 **Secondary Causes of Hypertension**
8-9 a.m.—Greater Paterson General
Hospital, Wayne
(*Greater Paterson General Hospital and
AMNJ*)
- 5 **Gastrointestinal Bleeding**
8-9 p.m.—Burdette Tomlin Memorial
Hospital, Cape May Courthouse
(*Burdette Tomlin Memorial Hospital and
AMNJ*)
- 5 **Colorectal Carcinoma**
5-6 p.m.—Rutgers Medical School,
Piscataway
(*CMDNJ and AMNJ*)
- 5 **Medical Emergency Care**
- 12 **Colitis**
- 19 **Medical Genetics**
11 a.m.-12 noon—Greystone Park
Psychiatric Hospital
(*Greystone Park Psychiatric Hospital and
AMNJ*)
- 5 **Seminar on Law and Psychiatry**
12 3:30-5:30 p.m.—Rutgers Law School,
19 Newark
26 (*Rutgers University Law School and
AMNJ*)
- 6 **Genetics**
- 13 **Septic Shock**
1-3 p.m.—Christ Hospital, Jersey City
(*Christ Hospital and AMNJ*)
- 6 **Lectures in Obstetrics and Gynecology**
8-10 p.m.—Location Varies
(*CMDNJ and AMNJ*)
- 6 **Sepsis and Endotoxic Shock**
10:30 a.m.-12 noon—St. Mary's
Hospital, Passaic
(*St. Mary's Hospital and AMNJ*)
- 6 **Psychiatric Emergencies**
- 20 **Antianxiety and Antidepressants**
1-3 p.m.—Ancora Psychiatric Hospital,
Hammonton
(*Ancora Psychiatric Hospital and AMNJ*)
- 6 **Systemic Mycoses**
- 13 **Nutritional Issues in Clinical Medicine**
- 20 **Endocrine Aspects of Aging**
9-11 a.m.—Middlesex General Hospital,
New Brunswick
(*Middlesex General Hospital, AMNJ and
AAFP*)
- 6 **Medical Grand Rounds**
11:30 a.m.—Rotates between Newark
Beth Israel Medical Center, Martland,
and East Orange VA Hospitals
(*AMNJ Endocrinology Section*)
- 6 **Endocrinology—Dinner Meeting**
6:30-9:30 p.m.—Holiday Inn, East
Orange
(*AMNJ Endocrinology Section*)
- 6 **Advances in Medicine**
- 13 9:30-11 a.m.—Bergen Pines County
20 Hospital, Paramus
27 (*Bergen Pines County Hospital and
AMNJ*)
- 6 **Continuing Education in Psychiatry**
- 13 1-3 p.m.—Bergen Pines County
20 Hospital, Paramus
27 Paramus
(*Bergen Pines Hospital and AMNJ*)
- 6 **Individualization of Drug Therapy**
- 13 **Dizziness**
- 20 **Chemistry Laboratory and Liver Disease**
9-11 a.m.—Riverview Hospital, Red
Bank
(*Riverview Hospital and AMNJ*)
- 6 **The Anxiety Syndrome**
- 13 **Antibiotic Rx**
- 20 **Common Hematologic Problems**
11:30 a.m.-1:30 p.m.—Rahway Hospital
(*Rahway Hospital and AAFP*)
- 6 **Grand Rounds and Case Presentations**
- 13 2-4 p.m.—Rotates between Martland,
20 Newark Beth Israel, St. Michael's, St.
27 Joseph's Hospital, and Jersey City
Medical Center
(*CMDNJ and AMNJ*)
- 6 **Clinical Pathology Grand Rounds**
- 13 12 noon-1 p.m.—New Jersey Medical
20 School, Newark
27 (*CMDNJ and AMNJ*)
- 7 **Psychiatric Lecture Series**
- 14 11 a.m.-12 noon—Greystone Psychiatric
21 Hospital
(*Greystone Psychiatric Hospital and
AMNJ*)
- 7 **Neurosurgical Case Presentations**
- 14 4-5:30 p.m.—NJ Medical School,
21 Newark
(*CMDNJ and AMNJ*)
- 7 **Writing Your Clinical Paper**
7-8:30 p.m.—NJ Medical School,
Newark
(*CMDNJ and AMNJ*)
- 7 **Virology**
- 14 4-6 p.m.—Institute for Medical
Research, Copewood St., Camden
(*Institute for Medical Research and
AMNJ*)
- 7 **Normal Diet—Food Fads & Vitamins**
- 12 **Weight Control, Diet, and Pregnancy**
- 14 **Lipid Profile**
11:45 a.m.-12:45 p.m.—John F.
Kennedy Medical Center, Edison
(*John F. Kennedy Medical Center*)
- 7 **Grand Rounds and Case Presentations**
- 14 4-5 p.m.—Martland Hospital, Newark
21 (*CMDNJ and AMNJ*)
- 28
- 7 **Psychiatric Ethics**
- 14 **Hysterical Dissociation**
12 noon-1 p.m.—Carrier Foundation,
Belle Mead
(*The Carrier Foundation*)
- 7 **Psychotherapeutic Techniques**
8-10 p.m.—312 Harding Drive, South
Orange
(*Group for Advanced Psychiatric Study
and AMNJ*)
- 7 **Cardiology Conferences**
- 14 2:15-4:15 p.m.—Deborah Heart and
21 Lung Center, Browns Mills
28 (*Deborah Heart and Lung Center and
AMNJ*)
- 11 **Problem Cases in Cancer**
7:45-9 a.m.—Newark Beth Israel
Medical Center
(*Newark Beth Israel Medical Center and
AMNJ*)
- 12 **Stress Testing**
8-9 a.m.—Garden State Community
Hospital, Marlton
(*Garden State Community Hospital and
AMNJ*)
- 12 **Clinical Pharmacology**
12-3 p.m.—Ancora Psychiatric Hospital,
Hammonton
(*Ancora Psychiatric Hospital and AMNJ*)
- 12 **Pulmonary Disease-Proper Use of Blood
Gases**
8:30-9:30 p.m.—Omar's Restaurant,
Saddle River Road, Fair Lawn
(*Fair Lawn Memorial Hospital and
AMNJ*)
- 13 **Endocrine Conferences**
- 20 3:30-5 p.m.—Rotates between Newark
27 Beth Israel Medical Center, Martland,
and East Orange VA Hospitals
(*AMNJ*)
- 13 **Depression**
9:30-11:30 a.m.—Dover General
Hospital
(*Riverside, Dover General, St. Clare's
Hospitals and AMNJ*)
- 13 **The New Immigrant in America**
1:30-3 p.m.—NJ Medical School,
Newark
(*CMDNJ and AMNJ*)
- 13 **Uveitis Problems**
7:15-9:30 p.m.—United Hospitals
Medical Center, Newark
(*Associated Eye Residences of NJ and
AMNJ*)
- 14 **The Alcoholic Patient**
5-6:30 p.m.—Somerset Hospital,
Somerville
(*Somerset Hospital and AMNJ*)
- 14 **Case Presentations and Guest Speakers**
7:30-9:30 p.m.—Location to be
announced

- (*New Jersey Institute of Ultrasound in Medicine and AMNJ*)
- 15 **Management of the Juvenile Diabetic**
8:15-10:30 a.m.—Overlook Hospital, Summit
(*Overlook Hospital and AMNJ*)
- 19 **Cardiopulmonary Complications of the Surgical Patient**
8-10 p.m.—The Englewood Club, Englewood
(*Englewood Surgical Society and AMNJ*)
- 19 **Adrenal Diseases**
11:30 a.m.-12:30 p.m.—St. Mary's Hospital, Orange
(*St. Mary's Hospital and AMNJ*)
- 20 **Diagnosis and Management of Shock**
1-2 p.m.—Trenton Psychiatric Hospital
(*Trenton Psychiatric Hospital and AMNJ*)
- 20 **Tracheobronchial Tree and Environmental Hazards**
11:30 a.m.-1 p.m.—VA Hospital, East Orange
(*VA Hospital and AMNJ*)
- 27 **Neuropathology Conferences**
8-9:15 a.m.—New Jersey Medical School, Newark
(*CMDNJ and AMNJ*)
- 27 **Cardiac Grand Rounds**
3-4:30 p.m.—NJ Medical School, Newark
(*American Heart Association, NJ Affiliate and AMNJ*)
- Jan.
- 2 **Seminar on Law and Psychiatry**
9 3:30-5:30 p.m.—Rutgers Law School, Newark
16 (*Rutgers University Law School and AMNJ*)
- 3 **Lectures in Obstetrics and Gynecology**
8-10 p.m.—Location Varies
(*CMDNJ and AMNJ*)
- 3 **Endocrinology—Dinner Meeting**
6:30-9:30 p.m.—Holiday Inn, East Orange
(*AMNJ Endocrinology Section*)
- 3 **Medical Grand Rounds**
11:30 a.m.—Rotates between Newark Beth Israel Medical Center, Martland and East Orange VA Hospitals
(*AMNJ*)
- 3 **Seizure Disorders, Diagnosis and Management**
- 31 **Congenital Diseases**
10:30 a.m.-12 noon—St. Mary's Hospital, Passaic
(*St. Mary's Hospital and AMNJ*)
- 3 **Psychopharmacology Update**
- 17 **Epilepsy and Convulsive Disorders**
- 31 **Psychosomatic Medicine**
1-3 p.m.—Ancora Psychiatric Hospital, Hammonton
(*Ancora Psychiatric Hospital and AMNJ*)
- 3 **Immunology: Clinical**
- 10 **Peripheral Vascular Disorders**
- 17 **Difficult Biliary Problems**
- 24 **Granulomatous Bowel Diseases**
- 31 **Sports Medicine**
1-3 p.m.—Christ Hospital, Jersey City
(*Christ Hospital and AMNJ*)
- 3 **Drugs and Pregnancy**
- 10 **Adolescent Health Care**
- 17 **The Addictive Personality: Drug and Alcohol Dependence**
- 24 **Drug Therapy in Psychiatric Disorders of Older Patients**
- 31 **Management of Acute and Chronic Alcoholism in Clinical Patients**
9-11 a.m.—Middlesex General Hospital, New Brunswick
(*Middlesex General Hospital, AMNJ and AAFP*)
- 3 **Grand Rounds and Case Presentations**
10 2-4 p.m.—Rotating between Martland, Newark Beth Israel, St. Michael's, St. Joseph's Hospitals, and Jersey City Medical Center
(*CMDNJ and AMNJ*)
- 3 **Clinical Pathology Grand Rounds**
10 12 noon-1 p.m.—NJ Medical School, Newark
17 (*CMDNJ and AMNJ*)
- 31 **Advances in Medicine**
10 9:30-11 a.m.—Bergen Pines County Hospital, Paramus
17 (*Bergen Pines County Hospital and AMNJ*)
- 3 **Endocrine Conference**
10 3:30-5 p.m.—Rotates between Newark Beth Israel Medical Center, Martland, and East Orange VA Hospitals
17 (*AMNJ Endocrinology Section*)
- 3 **Clinical Enzymology**
- 10 **Complications of Diabetes**
- 17 **The Common Hyperlipoproteinemias**
- 24 **Lower Gastrointestinal Bleeding**
- 31 **Treatment of Patients with Major Burns**
9-11 a.m.—Riverview Hospital, Red Bank
(*Riverview Hospital and AMNJ*)
- 4 **Arthritides**
- 9 **Vaginal Bleeding**
- 11 **Rheumatic Fever**
- 18 **Surgery and Arthritis**
- 25 **X-ray of the Spine**
11:45 a.m.-12:45 p.m.—John F. Kennedy Hospital, Edison
(*John F. Kennedy Hospital*)
- 4 **Neurosurgical Case Presentations**
11 4-5:30 p.m.—NJ Medical School, Newark
18 (*CMDNJ and AMNJ*)
- 4 **Virology**
11 4-6 p.m.—Institute for Medical Research, Copewood St., Camden
18 (*Institute for Medical Research and AMNJ*)
- 4 **Psychotherapeutic Techniques**
8-10 p.m.—312 Harding Drive, South Orange
(*Group for Advanced Psychiatric Study and AMNJ*)
- 4 **Psychiatric Lecture Series**
11 11 a.m.-12 noon—Greystone Park Psychiatric Hospital
18 (*Greystone Park Psychiatric Hospital and AMNJ*)
- 4 **Grand Rounds and Case Presentations**
11 4-5 p.m.—Martland Hospital, Newark
18 (*CMDNJ and AMNJ*)
- 4 **Cardiology Conferences**
11 2:15-4:15 p.m.—Deborah Heart and Lung Center, Browns Mills
18 (*Deborah Heart and Lung Center and AMNJ*)
- 5 **Obesity**
8:30-9:30 a.m.—United Hospitals of Newark
- (*United Hospitals of Newark and AMNJ*)
- 5 **Diagnostic and Therapeutic Problems in Orthopedics**
12 7:30-9 a.m.—Alexian Brothers Hospital, Elizabeth
26 (*Alexian Brothers Hospital*)
- 5 **Advances in Pediatrics**
12 9:30-10:30 a.m.—NJ Medical School, Newark
19 (*CMDNJ and AMNJ*)
- 8 **Lecture Series in Surgery**
15 4:30-5:30 p.m.—NJ Medical School, Newark
21 (*CMDNJ and AMNJ*)
- 8 **Psychiatric Lecture Series**
8-10 p.m.—111 Ridgewood Ave., Glen Ridge
(*Essex Psychiatric Seminar and AMNJ*)
- 8 **Neuroscience Conferences**
15 11:30 a.m.-12:30 p.m.—Bergen Pines County Hospital, Paramus
22 (*Bergen Pines County Hospital and AMNJ*)
- 9 **Bleeding Diseases**
- 16 **Diagnosis of Anemic Patient**
- 23 **Management of Hepatitis**
11 a.m.-12 noon—Greystone Park Psychiatric Hospital
(*Greystone Park Psychiatric Hospital and AMNJ*)
- 9 **Skin Infections**
8-10 p.m.—Schering Corporation, Kenilworth
(*NJ Dermatological Society and AMNJ*)
- 9 **Lower Limb Grafting Procedures**
8-9 a.m.—Greater Paterson General Hospital, Wayne
(*Greater Paterson General Hospital and AMNJ*)
- 10 **Nutrition Update**
9:30-11:30 a.m.—Dover General Hospital
(*Riverside, Dover General, St. Clare's Hospitals and AMNJ*)
- 10 **Depression in the Community**
- 24 **Child Psychology**
1:30-3 p.m.—NJ Medical School, Newark
(*CMDNJ and AMNJ*)
- 10 **Alcoholism**
11:30 a.m.-12:30 p.m.—Rahway Hospital
(*Rahway Hospital and AMNJ*)
- 10 **Cerebral Vascular Disease**
1:30-2:30 p.m.—John E. Runnells Hospital, Berkeley Heights
(*John E. Runnells Hospital and AMNJ*)
- 11 **Psychogeography**
8:30-10:30 p.m.—Hackensack Hospital
(*Hackensack Hospital and AMNJ*)
- 11 **Case Presentations with Guest Speakers**
7:30-9:30 p.m.—Location to be announced
(*NJ Institute of Ultrasound in Medicine and AMNJ*)
- 16 **Hepatitis**
7-8 p.m.—Irvington General Hospital
(*Irvington General Hospital and AMNJ*)
- 16 **Seizure Disorders**
11:30 a.m.-12:30 p.m.—St. Mary's Hospital, Orange
(*St. Mary's Hospital and AMNJ*)
- 17 **Thanatology**
1-2 p.m.—Trenton Psychiatric Hospital
(*Trenton Psychiatric Hospital and AMNJ*)

- 18 **Aneurysms of the Aorta**
7:15-10:15 p.m.—Hospital Center at Orange
(*Diagnostic Radiology Section for Northern New Jersey and AMNJ*)
- 18 **Management of Breast Cancer**
5-6:30 p.m.—Somerset Hospital, Somerville
(*Somerset Hospital and AMNJ*)
- 23 **Alcoholism**
8-9 p.m.—Warren Hospital, Phillipsburg
(*Warren Hospital and AMNJ*)
- 23 **Fundamentals of Hemostasis for Surgeons**
8-10 p.m.—The Englewood Club, Englewood
(*Englewood Surgical Society and AMNJ*)
- 24 **Neuropathology Conferences**
8-9:15 a.m.—NJ Medical School, Newark
(*CMDNJ and AMNJ*)
- 27 **NJPA Annual Meeting**
9 a.m.-4 p.m.—Buck Hill Inn, Pa.
(*NJ Psychiatric Association and AMNJ*)
- 31 **Cardiac Grand Rounds**
3-4:30 p.m.—NJ Medical School, Newark
(*American Heart Association, NJ Affiliate and AMNJ*)
- Feb.**
- 1 **Psychotherapeutic Techniques**
8-10 p.m.—312 Harding Drive, South Orange
(*Group for Advanced Psychiatric Study and AMNJ*)
- 1 **Psychiatric Lecture Series**
- 8 11 a.m.-12 noon—Greystone Park
- 15 Psychiatric Hospital
- 22 (*Greystone Park Psychiatric Hospital and AMNJ*)
- 1 **Grand Rounds and Case Presentations**
- 8 4-5 p.m.—Martland Hospital, Newark
(*CMDNJ and AMNJ*)
- 15 (*CMDNJ and AMNJ*)
- 22
- 1 **Cardiology Conferences**
- 8 2:15-4:15 p.m.—Deborah Heart and
- 15 Lung Center, Browns Mills
- 22 (*Deborah Heart and Lung Center and AMNJ*)
- 1 **Virology**
- 8 4-6 p.m.—Institute for Medical
- 15 Research, Copewood St., Camden
- 22 (*Institute for Medical Research and AMNJ*)
- 1 **Neurosurgical Case Presentations**
- 8 4-5:30 p.m.—NJ Medical School,
- 15 Newark
- 22 (*CMDNJ and AMNJ*)
- 2 **Advances in Pediatrics**
- 9 9:30-10:30 a.m.—NJ Medical School,
- 16 Newark
- 23 (*CMDNJ and AMNJ*)
- 2 **Antiarrhythmic Medications**
- 9 Hypertension Update
- 14 Toxemia of Pregnancy
- 16 Radiology of the Heart—X-ray, Scan, & Echo
- 23 **Differential Dx of Heartblocks**
11:45-12:45 p.m.—John F. Kennedy Medical Center, Edison
(*John F. Kennedy Medical Center*)
- 2 **Head and Neck Cancer**
8:30-9:30 a.m.—United Hospitals of Newark
(*United Hospitals of Newark and AMNJ*)
- 2 **Diagnostic and Therapeutic Problems in Orthopedics**
- 9
- 23 7:30-9 a.m.—Alexian Brothers Hospital, Elizabeth
(*Alexian Brothers Hospital*)
- 5 **Intermittent Treatment of a Schizophrenic**
8-10 p.m.—39 Crescent Ave., Passaic
(*Essex Psychiatric Seminar and AMNJ*)
- 5 **Neuroscience Conferences**
- 12 11:30 a.m.-12:30 p.m.—Bergen Pines
- 19 County Hospital, Paramus
- 26 (*Bergen Pines County Hospital and AMNJ*)
- 5 **Lecture Series in Surgery**
- 12 4:30-5:30 p.m.—NJ Medical School,
- 19 Newark
- 26 (*CMDNJ and AMNJ*)
- 6 **Neurology: Headache**
8-9 p.m.—Burdette Tomlin Memorial Hospital, Cape May Court House
(*Burdette Tomlin Memorial Hospital and AMNJ*)
- 6 **Seminar on Law and Psychiatry**
- 13 3:30-5:30 p.m.—Rutgers Law School,
- 20 Newark
- 27 (*Rutgers University Law School and AMNJ*)
- 7 **Lectures in Obstetrics and Gynecology**
8-10 p.m.—Location varies
(*CMDNJ and AMNJ*)
- 7 **Endocrinology—Dinner Meeting**
6:30-9:30 p.m.—Holiday Inn, East Orange
(*AMNJ Endocrinology Section*)
- 7 **Medical Grand Rounds**
11:30 a.m.—Rotates between Newark Beth Israel Medical Center, Martland, and East Orange VA Hospitals
(*AMNJ*)
- 7 **Environmental Hazards**
9:30-11:30 a.m.—Dover General Hospital
(*Riverside, Dover General, St. Clare's Hospitals and AMNJ*)
- 7 **Depression**
- 21 Title to be announced
- 1:30-3 p.m.—NJ Medical School, Newark
(*CMDNJ and AMNJ*)
- 7 **Childhood Leukemia and Solid Tumors**
- 14 **Current Concepts in Ulcer Disease**
- 21 **Inflammatory Bowel Disease**
- 28 **Ischemic Brain Syndromes**
9-11 a.m.—Riverview Hospital, Red Bank
(*Riverview Hospital and AMNJ*)
- 7 **Infertility, Diagnosis and Management**
10:30 a.m.-12 noon—St. Mary's Hospital, Passaic
(*St. Mary's Hospital and AMNJ*)
- 7 **Obesity**
11:30 a.m.-12:30 p.m.—Rahway Hospital
(*Rahway Hospital and AMNJ*)
- 7 **Psychosomatic Medicine**
- 14 **Hospital Psychiatry—Principles**
- 21 **Hospital Psychiatry—Rx**
1-3 p.m.—Ancora Psychiatric Hospital, Hammonton
(*Ancora Psychiatric Hospital and AMNJ*)
- 7 **Nephrology: Fluid and Electrolyte Imbalance**
- 14 **Physiological Parameters in Critical Care Therapy**
- 21 **Rehabilitation Surgery**
- 1-3 p.m.—Christ Hospital, Jersey City
(*Christ Hospital, AMNJ, and AAFP*)
- 7 **Urinary Tract Infections**
- 14 **Blood Pressure and the Kidney**
- 21 **Diuresis and Antidiuresis**
- 28 **Digestive Disease**
9-11 a.m.—Middlesex General Hospital, New Brunswick
(*Middlesex General Hospital, AMNJ and AAFP*)
- 7 **Grand Rounds and Case Presentations**
- 14 2-4 p.m.—Rotating between Martland,
- 21 Newark Beth Israel, St. Michael's, St.
- 28 Joseph's Hospitals and Jersey City Medical Center
(*CMDNJ and AMNJ*)
- 7 **Clinical Pathology Grand Rounds**
- 14 12 noon-1 p.m.—NJ Medical School,
- 21 Newark
- 28 (*CMDNJ and AMNJ*)
- 7 **Advances in Medicine**
- 14 9:30 a.m.-11 a.m.—Bergen Pines County
- 21 Hospital, Paramus
- 28 (*Bergen Pines County Hospital and AMNJ*)
- 7 **Endocrine Conferences**
- 14 3:30-5 p.m.—Rotates between Newark
- 21 Beth Israel Medical Center, Martland,
- 28 and East Orange VA Hospitals
(*AMNJ*)
- 8 **The Voice of Conscience**
8:30-10:30 p.m.—Location to be announced
(*NJ Psychoanalytic Society and AMNJ*)
- 8 **Case Presentations and Guest Speakers**
7:30-9:30 p.m.—Location to be announced
(*NJ Institute of Ultrasound in Medicine and AMNJ*)
- 13 **Clinical Immunology**
- 20 **Sepsis Shock**
- 27 **Laboratory Interpretations**
11 a.m.-12 noon—Greystone Park Psychiatric Hospital
(*Greystone Park Psychiatric Hospital and AMNJ*)
- 13 **Bullous Diseases**
8-10 p.m.—Schering Corporation, Kenilworth
(*NJ Dermatological Society and AMNJ*)
- 14 **Blood Gases**
1:30-2:30 p.m.—John E. Runnells Hospital, Berkeley Heights
(*John E. Runnells Hospital and AMNJ*)
- 15 **Impact of Genetics on Medical Practice**
5-6:30 p.m.—Somerset Hospital, Somerville
(*Somerset Hospital and AMNJ*)
- 20 **Infectious Diseases—Endotoxic Shock**
7-8 p.m.—Irvington General Hospital
(*Irvington General Hospital and AMNJ*)
- 20 **Breast Cancer**
11:30 a.m.-12:30 p.m.—St. Mary's Hospital, Orange
(*St. Mary's Hospital and AMNJ*)
- 21 **Addicts**
1-2 p.m.—Trenton Psychiatric Hospital
(*Trenton Psychiatric Hospital and AMNJ*)
- 27 **Malpractice**
8-9 p.m.—Warren Hospital, Phillipsburg
(*Warren Hospital and AMNJ*)
- 27 **Ultrasound Diagnosis**
8-10 p.m.—The Englewood Club, Englewood
(*Englewood Surgical Society and AMNJ*)

28	Neuropathology Conferences 8-9:15 a.m.—NJ Medical School, Newark (CMDNJ and AMNJ)	5	Neuroscience Conferences 12 11:30 a.m.-12:30 p.m.—Bergen Pines 19 County Hospital, Paramus 26 (Bergen Pines County Hospital and AMNJ)	New Brunswick (Middlesex General Hospital, AMNJ and AAFP)
28	Cardiac Grand Rounds 3-4:30 p.m.—NJ Medical School, Newark (American Heart Association, NJ Affiliate and AMNJ)	5	Lecture Series in Surgery 12 4:30-5:30 p.m.—NJ Medical School, 19 Newark 26 (CMDNJ and AMNJ)	7 Grand Rounds and Case Presentations 14 2-4 p.m.—Rotating between Martland, 21 Newark Beth Israel, St. Michael's, St. 28 Joseph's Hospitals and Jersey City Medical Center (CMDNJ and AMNJ)
Mar.		6	Seminar on Law and Psychiatry 13 3:30-5:30 p.m.—Rutgers Law School, 20 Newark 27 (Rutgers University Law School and AMNJ)	7 Clinical Pathology Grand Rounds 14 12 noon-1 p.m.—NJ Medical School, 21 Newark 28 (CMDNJ and AMNJ)
1	Psychotherapeutic Techniques 8-10 p.m.—312 Harding Drive, South Orange (Group for Advanced Psychiatric Study and AMNJ)	6	Hypertension in Cardiovascular Renal Disease 13 Psychotropic Drugs for Cardiac Patients 8-9 a.m.—Greater Paterson General Hospital, Wayne (Greater Paterson General Hospital and AMNJ)	7 Advances in Medicine 14 9:30 a.m.-11 a.m.—Bergen Pines County 21 Hospital, Paramus 28 (Bergen Pines County Hospital and AMNJ)
1	Psychiatric Lecture Series 8 11 a.m.-12 noon—Greystone Park 15 Psychiatric Hospital 22 (Greystone Park Psychiatric Hospital and AMNJ)	7	Early Steroid Hormone Exposure 21 The Fourth Mental Health Revolution 1:30-3 p.m.—NJ Medical School, Newark (CMDNJ and AMNJ)	7 Endocrine Conferences 14 3:30-5 p.m.—Rotates between Newark 21 Beth Israel Medical Center, Martland, 28 and East Orange VA Hospitals (AMNJ)
1	Grand Rounds and Case Presentations 8 4-5 p.m.—Martland Hospital, Newark 15 (CMDNJ and AMNJ)	7	Immunologic Response to Lymphocyte Function 14 Nuclear Cardiology 21 Infectious Diseases 9-11 a.m.—Riverview Hospital, Red Bank (Riverview Hospital and AMNJ)	7 Gall Bladder Disease 14 Diabetic Retinopathy and Retinal Neovascularization 28 Renal Failure 9:30-11:30 a.m.—Dover General Hospital (Riverside, Dover General, St. Clare's Hospitals and AMNJ)
1	Cardiology Conferences 8 2:15-4:15 p.m.—Deborah Heart and Lung Center, Browns Mills 15 (Deborah Heart and Lung Center and AMNJ)	7	Course for Psychiatrists—Semester II 14 8-10 p.m.—Hackensack Hospital 21 (NJ Psychoanalytic Society and AMNJ)	8 Virology 15 4-6 p.m.—Institute for Medical 22 Research, Copewood St., Camden 29 (Institute for Medical Research and AMNJ)
1	Neurosurgical Case Presentations 8 4-5:30 p.m.—NJ Medical School, Newark 15 (CMDNJ and AMNJ)	7	Lectures in Obstetrics and Gynecology 8-10 p.m.—Location varies (CMDNJ and AMNJ)	8 Case Presentations and Guest Speakers 7:30-9:30 p.m.—Location to be announced (NJ Institute of Ultrasound in Medicine and AMNJ)
2	Annual Edward G. Waters Gynecologic Conference 3 Begins 8:30 a.m.—Playboy Club, Great Gorge 4 (CMDNJ and AMNJ)	7	Endocrinology—Dinner Meeting 6:30-9:30 p.m.—Holiday Inn, East Orange (AMNJ Endocrinology Section)	13 Acute Renal Failure 20 Chronic Renal Failure 27 Fluid and Electrolyte Imbalance 11 a.m.-12 noon—Greystone Park Psychiatric Hospital (Greystone Park Psychiatric Hospital and AMNJ)
2	Psychiatric Lecture Series 9 1:30-5 p.m.—Trenton Psychiatric Hospital 16 (Trenton Psychiatric Hospital and AMNJ)	7	Medical Grand Rounds 11:30 a.m.—Rotates between Newark Beth Israel Medical Center, Martland, and East Orange VA Hospitals (AMNJ)	13 Immunology 8-10 p.m.—Schering Corporation, Kenilworth (NJ Dermatological Society and AMNJ)
2	Lymphomas 9 Carcinoma of the Colon 14 CA of the Cervix 16 CA of the Urinary Tract 23 Chemotherapy Review 30 The Cancer Patient—Psychiatric Considerations 11:45 a.m.-12:45 p.m.—John F. Kennedy Medical Center, Edison (John F. Kennedy Medical Center)	7	Malpractice 11:30 a.m.-12:30 p.m.—Rahway Hospital (Rahway Hospital and AMNJ)	15 Treatment of Bronchospasm 5-6:30 p.m.—Somerset Hospital, Somerville (Somerset Hospital and AMNJ)
2	Advances in Pediatrics 9 9:30-10:30 a.m.—NJ Medical School, Newark 16 (CMDNJ and AMNJ)	7	Forensic Psychiatry—Concepts and Areas of Concern 14 Forensic Psychiatry—Recent Trends 21 Phobic and OBS, Compulsive Neurosis 1-3 p.m.—Ancora Psychiatric Hospital, Hammonton (Ancora Psychiatric Hospital and AMNJ)	15 Combined Radiology and Orthopedic Meeting 7:15-10:15 p.m.—Hospital Center at Orange (Diagnostic Radiology Section for Northern NJ and AMNJ)
2	Pharmacology, Clinical 8:30-9:30 a.m.—United Hospitals of Newark (United Hospitals of Newark and AMNJ)	7	Orthopedic Problems: Bone Tumors 14 Diabetes 21 To be announced 28 Patient Evaluation for Surgery 1-3 p.m.—Christ Hospital, Jersey City (Christ Hospital and AMNJ)	20 Surgical Management—Ulcerative Colitis 7-8 p.m.—Irvington General Hospital (Irvington General Hospital and AMNJ)
2	Diagnostic and Therapeutic Problems in Orthopedics 9 7:30-9 a.m.—Alexian Brothers Hospital, Elizabeth (Alexian Brothers Hospital)	7	Vasodilator Therapy in Heart Disease 14 Current Problems in Transplantation 21 Gastrointestinal Disorders Among Children 28 Psychopathology of Sexual Dysfunction 9-11 a.m.—Middlesex General Hospital,	20 Nuclear Medicine 11:30 a.m.-12:30 p.m.—St. Mary's Hospital, Orange (St. Mary's Hospital and AMNJ)
5	An Adolescent Girl in a Lolie a deux 8-10 p.m.—111 Ridgewood Ave., Glen Ridge (Essex Psychiatric Seminar and AMNJ)	7		20 Proper Use of Endoscopy 8:30-9:30 p.m.—Omar's Restaurant, Saddle River Rd., Fair Lawn (Fair Lawn Memorial Hospital and AMNJ)
		23		Young Freud & Friends—Joint Meeting 8-10 p.m.—Town & Campus, West

Orange
(*NJ Psychoanalytic Society, NJ
Psychiatric Association and AMNJ*)

27 **Head and Neck Cancer**
8-9 p.m.—Warren Hospital, Phillipsburg
(*Warren Hospital and AMNJ*)

28 **Neuropathology Conferences**
8-9:15 a.m.—NJ Medical School,
Newark
(*CMDNJ and AMNJ*)

28 **Cardiac Grand Rounds**
3-4:30 p.m.—NJ Medical School,
Newark
(*American Heart Association, NJ
Affiliate and AMNJ*)

Apr.

2 **Voyeurism and Sexual Deviation in a
Young Man**
8-10 p.m.—60 Melrose Place, Montclair
(*Essex Psychiatric Seminar and AMNJ*)

2 **Neuroscience Conferences**
9 11:30 a.m.-12:30 p.m.—Bergen Pines
16 County Hospital, Paramus
23 (*Bergen Pines County Hospital and
30 AMNJ*)

2 **Lecture Series in Surgery**
9 4:30-5:30 p.m.—NJ Medical School,
16 Newark
23 (*CMDNJ and AMNJ*)
30

3 **Malpractice**
8-9 p.m.—Burdette Tomlin Memorial
Hospital, Cape May Court House
(*Burdette Tomlin Memorial Hospital and
AMNJ*)

3 **Seminar on Law and Psychiatry**
10 3:30-5:30 p.m.—Rutgers Law School,
17 Newark
24 (*Rutgers University Law School and
AMNJ*)

4 **Lectures in Obstetrics and Gynecology**
8-10 p.m.—Location varies
(*CMDNJ and AMNJ*)

4 **Endocrinology—Dinner Meeting**
6:30-9:30 p.m.—Holiday Inn, East
Orange
(*AMNJ Endocrinology Section*)

4 **Medical Grand Rounds**
11:30 a.m.—Rotates between Newark
Beth Israel Medical Center, Martland,
and East Orange VA Hospitals
(*AMNJ Endocrinology Section*)

4 **Lung Disorders and Blood Gases**
10:30 a.m.-12 noon—St. Mary's
Hospital, Passaic
(*St. Mary's Hospital and AMNJ*)

4 **Clinical Pharmacology**
11:30 a.m.-12:30 p.m.—Rahway
Hospital
(*Rahway Hospital and AMNJ*)

4 **Violence-Evaluation/Concepts**

18 **Psychological Testing**
1-3 p.m.—Ancora Psychiatric Hospital,
Hammonton
(*Ancora Psychiatric Hospital and AMNJ*)

4 **Medical Lecture Series**
18 1-3 p.m.—Christ Hospital, Jersey City
25 (*Christ Hospital and AMNJ*)

4 **Nonmalignant Disorders of the Bowel**
11 **Fever of Obscure Origin**
18 **Contact Dermatitis—1979**
25 **Colorectal Polyps and Cancers**
9-11 a.m.—Middlesex General Hospital,
New Brunswick

(*Middlesex General Hospital, AMNJ and
AAFP*)

4 **Grand Rounds and Case Presentations**
11 2-4 p.m.—Rotating between Martland,
18 Newark Beth Israel, St. Michael's, St.
25 Joseph's Hospitals and Jersey City
Medical Center
(*CMDNJ and AMNJ*)

4 **Clinical Pathology Grand Rounds**
11 12 noon-1 p.m.—NJ Medical School,
18 Newark
25 (*CMDNJ and AMNJ*)

4 **Advances in Medicine**
11 9:30-11 a.m.—Bergen Pines County
18 Hospital, Paramus
25 (*Bergen Pines County Hospital and
AMNJ*)

4 **Endocrine Conferences**
11 3:30-5 p.m.—Rotates between Newark
18 Beth Israel Medical Center, Martland,
25 and East Orange VA Hospitals
(*AMNJ*)

4 **Congenital Heart in Adults**
9:30-11:30 a.m.—Dover General
Hospital
(*Riverside, Dover General, St. Clare's
Hospital and AMNJ*)

4 **Delayed Grief Reactions**
18 **Hyperactive Children**
1:30-3 p.m.—NJ Medical School,
Newark
(*CMDNJ and AMNJ*)

4 **Course for Psychiatrists—Semester II**
11 8-10 p.m.—Hackensack Hospital
18 (*NJ Psychoanalytic Society and AMNJ*)
25

5 **Neurosurgical Case Presentations**
12 4-5:30 p.m.—NJ Medical School,
19 Newark
(*CMDNJ and AMNJ*)

5 **Psychotherapeutic Techniques**
8-10 p.m.—312 Harding Drive, South
Orange
(*Group for Advanced Psychiatric Study
and AMNJ*)

5 **Psychiatric Lecture Series**
12 11 a.m.-12 noon—Greystone Park
19 Psychiatric Hospital
26 (*Greystone Park Psychiatric Hospital and
AMNJ*)

5 **Grand Rounds and Case Presentations**
12 4-5 p.m.—Martland Hospital, Newark
19 (*CMDNJ and AMNJ*)
26

5 **Cardiology Conferences**
12 2:15-4:15 p.m.—Deborah Heart and
19 Lung Center, Browns Mills
26 (*Deborah Heart and Lung Center and
AMNJ*)

6 **Arthritis**
8:30-9:30 a.m.—United Hospitals of
Newark
(*United Hospitals of Newark and AMNJ*)

6 **Diagnostic and Therapeutic Problems in
Orthopedics**
27 7:30-9 a.m.—Alexian Brothers Hospital,
Elizabeth
(*Alexian Brothers Hospital*)

6 **Advances in Pediatrics**
20 9:30-10:30 a.m.—NJ Medical School,
27 Newark
(*CMDNJ and AMNJ*)

6 **Acute Respiratory Failure**
11 **Practical Approach to Infertility**
13 **Bronchial Asthma Update**
20 **COPD and Rehabilitation**

27 **O₂ Therapy—Demonstrations, Arterial
Blood Gases**
11:45 a.m.-12:45 p.m.—John F.
Kennedy Hospital, Edison
(*John F. Kennedy Hospital and AMNJ*)

6 **Psychiatric Lecture Series**
20 1:30-5 p.m.—Trenton Psychiatric
27 Hospital
(*Trenton Psychiatric Hospital and
AMNJ*)

10 **Immunology**
8-10 p.m.—Schering Corporation,
Kenilworth
(*NJ Dermatological Society & AMNJ*)

10 **Cerebral Vascular Disease**
17 **Headache**
24 **Seizure Disorders**
11 a.m.-12 noon—Greystone Park
Psychiatric Hospital
(*Greystone Park Psychiatric Hospital and
AMNJ*)

11 **Depression and Anxiety**
1:30-2:30 p.m.—John E. Runnells
Hospital, Berkeley Heights
(*John E. Runnells Hospital and AMNJ*)

12 **Case Presentations and Guest Speakers**
7:30-9:30 p.m.—Location to be
announced
(*NJ Institute of Ultrasound in Medicine
and AMNJ*)

12 **Virology**
19 4-6 p.m.—Institute for Medical
26 Research, Copewood St., Camden
(*Institute for Medical Research and
AMNJ*)

17 **Colon and Rectal Cancer**
11:30 a.m.-12:30 p.m.—St. Mary's
Hospital, Orange
(*St. Mary's Hospital and AMNJ*)

18 **All-day Dental Symposium**
VA Hospital, East Orange
(*VA Hospital and AMNJ*)

18 **Advances in Thromboembolic Disease**
11:30 a.m.-1 p.m.—VA Hospital, East
Orange
(*VA Hospital and AMNJ*)

19 **Juvenile Diabetes**
5-6:30 p.m.—Somerset Hospital,
Somerville
(*Somerset Hospital and AMNJ*)

19 **Ultrasound**
7:15-10:15 p.m.—Hospital Center at
Orange
(*Diagnostic Radiology Section for
Northern New Jersey and AMNJ*)

24 **Lower Back Pain**
8-9 p.m.—Warren Hospital, Phillipsburg
(*Warren Hospital and AMNJ*)

24 **Upper GI Bleeding**
8-9 a.m.—Greater Paterson General
Hospital, Wayne
(*Greater Paterson General Hospital and
AMNJ*)

25 **Neuropathology Conferences**
8-9:15 a.m.—NJ Medical School,
Newark
(*CMDNJ and AMNJ*)

25 **Cardiac Grand Rounds**
3-4:30 p.m.—Medical School, Newark
(*American Heart Association, NJ
Affiliate and AMNJ*)

May

1 **Seminar on Law and Psychiatry**
8 3:30-5:30 p.m.—Rutgers Law School,
15 Newark

22	<i>(Rutgers University Law School and</i>	24	<i>(CMDNJ and AMNJ)</i>	10	Virology
29	<i>AMNJ)</i>	31		4-6 p.m.—Institute for Medical	
2	Lectures in Obstetrics and Gynecology	3	Psychotherapeutic Techniques	Research, Copewood St., Camden	
8-10 p.m.—Location varies		8-10 p.m.—312 Harding Drive, South		<i>(Institute for Medical Research and</i>	
<i>(CMDNJ and AMNJ)</i>		Orange		<i>AMNJ)</i>	
2	Endocrinology—Dinner Meeting	<i>(Group for Advanced Psychiatric Study</i>		12-	MSNJ Annual Meeting
6:30-9:30 p.m.—Holiday Inn, East		<i>and AMNJ)</i>		15	Holiday Inn/Howard Johnson, Atlantic
Orange		3	Psychiatric Lecture Series	City	
<i>(AMNJ Endocrinology Section)</i>		10	11 a.m.-12 noon—Greystone Park	15	Lung Cancer
2	Medical Grand Rounds	17	Psychiatric Hospital	11:30 a.m.-12:30 p.m.—St. Mary's	
11:30 a.m.—Rotates between Newark		24	<i>(Greystone Park Psychiatric Hospital and</i>	Hospital, Orange	
Beth Israel Medical Center, Martland,		<i>AMNJ)</i>		<i>(St. Mary's Hospital and AMNJ)</i>	
and East Orange VA Hospitals		3	Grand Rounds and Case Presentations	15	Breast Cancer
<i>(AMNJ)</i>		10	4-5 p.m.—Martland Hospital, Newark	7-8 p.m.—Irvington General Hospital	
2	Personality Disorders	17	<i>(CMDNJ and AMNJ)</i>	<i>(Irvington General Hospital and AMNJ)</i>	
11:30 a.m.-12:30 p.m.—Rahway		24		16	Child Rearing Implications from Group
Hospital		31		Dynamic Studies	
<i>(Rahway Hospital and AMNJ)</i>		3	Cardiology Conferences	30	Non-Verbal Communication
2	Clinical Pathology Grand Rounds	10	2:15-4:15 p.m.—Deborah Heart and	1:30-3 p.m.—NJ Medical School,	
12 noon-1 p.m.—NJ Medical School,		17	Lung Center, Browns Mills	Newark	
Newark		24	<i>(Deborah Heart and Lung Center and</i>	<i>(CMDNJ and AMNJ)</i>	
<i>(CMDNJ and AMNJ)</i>		31	<i>AMNJ)</i>	17	Current Therapy for Sexual Dysfunction
2	New Developments in Scanning	4	Advances in Pediatrics	5-6:30 p.m.—Somerset Hospital,	
30	Cerebral Vascular Disease	11	9:30-10:30 a.m.—NJ Medical School,	Somerville	
10:30 a.m.-12 noon—St. Mary's		18	Newark	<i>(Somerset Hospital and AMNJ)</i>	
Hospital, Passaic		25	<i>(CMDNJ and AMNJ)</i>	22	Suicidology
<i>(St. Mary's Hospital and AMNJ)</i>		9	Renal Function Tests and Interpretation	8-9 p.m.—Warren Hospital, Phillipsburg	
2	Psychology of Women—Research	9	Renal Diseases and Pregnancy	<i>(Warren Hospital and AMNJ)</i>	
16	Psychiatric Dx-Values	11	IVP in Ultrasound and Renal Diseases	23	Neuropathology Conferences
30	Physicians as Patients and their Families	18	Acid Base Imbalance	8-9:15 a.m.—Biomedical Sciences Bldg.,	
1-3 p.m.—Ancora Psychiatric Hospital,		26	Chronic Renal Failure	NJ Medical School	
Hammonont		11:45 a.m.-12:45 p.m.—John F.		<i>(CMDNJ and AMNJ)</i>	
<i>(Ancora Psychiatric Hospital and AMNJ)</i>		Kennedy Medical Center, Edison		23	Interstitial Pulmonary Disease
2	Medical Lecture Series	<i>(John F. Kennedy Medical Center)</i>		11:30 a.m.-1 p.m.—VA Hospital, East	
9	1-3 p.m.—Christ Hospital, Jersey City	4	Coronary Artery Disease	Orange	
16	<i>(Christ Hospital and AMNJ)</i>	8:30-9:30 a.m.—United Hospitals of		<i>(VA Hospital and AMNJ)</i>	
23		Newark		29	Drug Therapy of Chronic Obstructive
30		<i>(United Hospitals of Newark and AMNJ)</i>		Lung Disease	
2	Estrogen Replacement Therapy	4	Diagnostic and Therapeutic Problems in	8-9 a.m.—Greater Paterson General	
9	Dietary Enhancement of CNS	11	Orthopedics	Hospital, Wayne	
Neurotransmitters		25	7:30-9 a.m.—Alexian Brothers Hospital,	<i>(Greater Paterson General Hospital and</i>	
16	Hazards of Polypharmacy in Psychiatry	Elizabeth		<i>AMNJ)</i>	
23	Calcium-Phosphorus Homeostasis and	<i>(Alexian Brothers Hospital)</i>		30	Cardiac Grand Rounds
Metabolic Bone Disease		7	Depression in an Adolescent Girl	3-4:30 p.m.—NJ Medical School,	
9-11 a.m.—Middlesex General Hospital,		8-10 p.m.-1046 South Orange Avenue,		Newark	
New Brunswick		Short Hills		<i>(American Heart Association, NJ</i>	
<i>(Middlesex General Hospital, AMNJ,</i>		<i>(Essex Psychiatric Seminar and AMNJ)</i>		<i>Affiliate and AMNJ)</i>	
<i>and AAFP)</i>		7	Neuroscience Conferences		
2	Grand Rounds and Case Presentations	14	11:30 a.m.-12:30 p.m.—Bergen Pines		
9	2-4 p.m.—Rotating between Martland,	21	County Hospital, Paramus		
16	Newark Beth Israel, St. Michael's, St.	<i>(Bergen Pines County Hospital and</i>			
23	Joseph's Hospitals and Jersey City	<i>AMNJ)</i>			
30	Medical Center	7	Lecture Series in Surgery		
<i>(CMDNJ and AMNJ)</i>		14	4:30-5:30 p.m.—NJ Medical School,		
2	Advances in Medicine	21	Newark		
9	9:30 a.m.-11 a.m.—Bergen Pines County	<i>(CMDNJ and AMNJ)</i>			
16	Hospital, Paramus	8	Mycosis Fungoides		
23	<i>(Bergen Pines County Hospital and</i>	8-10 p.m.—Schering Corporation,			
30	<i>AMNJ)</i>	Kenilworth			
2	Endocrine Conferences	<i>(NJ Dermatological Society and AMNJ)</i>			
9	3:30-5 p.m.—Rotates between Newark	8	Malpractice		
16	Beth Israel Medical Center, Martland,	15	Breast Cancer		
23	Hospital and East Orange VA Hospitals	22	Current Chemotherapy		
30	<i>(AMNJ)</i>	11 a.m.-12 noon—Greystone Park			
2	Course for Psychiatrists	Psychiatric Hospital			
9	8-10 p.m.—Hackensack Hospital	<i>(Greystone Park Psychiatric Hospital and</i>			
<i>(NJ Psychoanalytic Society and AMNJ)</i>		<i>AMNJ)</i>			
2	Neurovascular Surgery	9	Suicidology		
23	Low Back Pain	1:30-2:30 p.m.—John E. Runnells			
9:30-11:30 a.m.—Dover General		Hospital, Berkeley Heights			
Hospital		<i>(John E. Runnells Hospital and AMNJ)</i>			
<i>(Riverside, Dover General, St. Clare's</i>					
<i>Hospitals and AMNJ)</i>		10	Case Presentations and Guest Speakers		
3	Neurosurgical Case Presentations	7:30-9:30 p.m.—Location to be			
10	4-5:30 p.m.—NJ Medical School,	announced			
17	Newark	<i>(NJ Institute of Ultrasound in Medicine</i>			
		<i>and AMNJ)</i>			
				June	
				1	Adrenal Diseases
				8:30-9:30 a.m.—United Hospitals of	
				Newark	
				<i>(United Hospitals of Newark and AMNJ)</i>	
				1	Diagnostic and Therapeutic Problems in
				8	Orthopedics
				22	7:30-9 a.m.—Alexian Brothers Hospital,
				Elizabeth	
				<i>(Alexian Brothers Hospital)</i>	
				4	Anorexia Nervosa
				8-10 p.m.—9 Marquette Road, Upper	
				Montclair	
				<i>(Essex Psychiatric Seminar and AMNJ)</i>	
				6	Endocrine Conferences
				3:30-5 p.m.—Rotates between Newark	
				Beth Israel Medical Center, Martland,	
				and East Orange VA Hospitals	
				<i>(AMNJ Endocrinology Section)</i>	
				6	Echocardiography
				13	Psychotropic Medication
				10:30 a.m.-12 noon—St. Mary's	
				Hospital, Passaic	
				<i>(St. Mary's Hospital and AMNJ)</i>	
				6	Depression—Outpatient Rx
				13	Psychodynamic Therapy for Outpatients

- 1-3 p.m.—Ancora Psychiatric Hospital, Hammonton
(Ancora Psychiatric Hospital and AMNJ)
- 6 **Advances in Medicine**
- 13 9:30 a.m.-11 a.m.—Bergen Pines County Hospital, Paramus
(Bergen Pines County Hospital and AMNJ)
- 6 **Medical Lecture Series**
- 13 1-3 p.m.—Christ Hospital, Jersey City
(Christ Hospital and AMNJ)
- 20
- 27
- 6 **Grand Rounds and Case Presentations**
- 13 2-4 p.m.—Rotating between Martland, Newark Beth Israel, St. Michael's, St. Joseph's Hospitals and Jersey City Medical Center
(CMDNJ and AMNJ)
- 20
- 27
- 6 **Clinical Pathology Grand Rounds**
- 13 12 noon-1 p.m.—NJ Medical School, Newark
(CMDNJ and AMNJ)
- 20
- 27
- 6 **Hypoglycemia**
- 13 **Diseases of the Esophagus**
9:30-11:30 a.m.—Dover General Hospital
(Riverside, Dover General, St. Clare's Hospitals and AMNJ)
- 7 **Psychotherapeutic Techniques**
8-10 p.m.—312 Harding Drive, South Orange
- (Group for Advanced Psychiatric Study and AMNJ)
- 7 **Grand Rounds and Case Presentations**
- 14 4-5 p.m.—Martland Hospital, Newark
(CMDNJ and AMNJ)
- 21
- 28
- 7 **Cardiology Conferences**
- 14 2:15-4:15 p.m.—Deborah Heart and Lung Center, Browns Mills
(Deborah Heart and Lung Center and AMNJ)
- 21
- 28
- 7- **Lectures**
- 10 Southampton Princess Hotel, Bermuda
(NJ Dermatological Society and AMNJ)
- 7 **Neurosurgical Case Presentations**
- 14 4-5:30 p.m.—NJ Medical School, Newark
(CMDNJ and AMNJ)
- 21
- 28
- 7 **Practical Dx and Treatment of Anemia**
- 12 **Anemia in Pregnancy**
- 14 **Dx and Treatment of Leukemia**
- 21 **Blood Disease Tests**
- 28 **Drug Interactions**
11:45 a.m.-12:45 p.m.—John F. Kennedy Medical Center, Edison
(John F. Kennedy Medical Center)
- 12 **Lower Back Pain**
- 19 **Clinical Shock**
- 26 **PSRO**
11 a.m.-12 noon—Greystone Park Psychiatric Hospital
(Greystone Park Psychiatric Hospital and AMNJ)
- 13 **Psychiatry in the United States**
1:30-3 p.m.—NJ Medical School, Newark
(CMDNJ and AMNJ)
- 14 **Lecture Series**
8:30-10:30 p.m.—Hackensack Hospital
(NJ Psychoanalytic Society and AMNJ)
- 14 **Case Presentations and Guest Speakers**
7:30-9:30 p.m.—Location to be announced
(NJ Institute of Ultrasound in Medicine and AMNJ)
- 19 **Peripheral Vascular Disease**
11:30 a.m.-12:30 p.m.—St. Mary's Hospital, Orange
(St. Mary's Hospital and AMNJ)
- 26 **Scanning, New Developments**
8-9 p.m.—Warren Hospital, Phillipsburg
(Warren Hospital and AMNJ)
- 27 **Neuropathology Conferences**
8-9:15 a.m.—NJ Medical School, Newark
(CMDNJ and AMNJ)
- 27 **Cardiac Grand Rounds**
3-4:30 p.m.—NJ Medical School, Newark
(American Heart Association, NJ Affiliate and AMNJ)

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Dr. Sidney R. Arbeit

Sidney R. Arbeit, M.D., one of Hudson County's renowned cardiologists, died suddenly on July 21 at Jewish Hospital and Rehabilitation Center of New Jersey, Jersey City, of an apparent heart ailment. Born in Jersey City, Dr. Arbeit earned his medical degree from Long Island College of Medicine, class of 1934, and served his internship at Jersey City Medical Center. He practiced general medicine until the outbreak of World War II during which he served three and a half years in Alaska in the Medical Department of the Army. Upon return to private practice he concentrated in the field of cardiology, becoming chief of that department at the Jersey City Medical Center and at the Jewish Hospital there. He also was affiliated with Montefiore Hospital in New York City and was Clinical Associate Professor of Medicine at New Jersey Medical School, CMDNJ, Newark. In addition Dr. Arbeit served as chairman of the board of managers of the Medical Center and president of the staff at the Jewish Hospital, and was the author of five books on heart disease and many articles for cardiology journals. He was a Fellow of the American College of Cardiology. His avocations included woodworking and he made many fine pieces. Dr. Arbeit was 68 years old at the time of his death.

Dr. John A. Casazza

A member of our Monmouth County component, John A. Casazza, M.D., died on July 27 at Riverview Hospital, Red Bank. A native of New York City, Dr. Casazza was graduated from Georgetown University Medical School, class of 1956, and upon completion of internship served two years with the Department of Medicine of the United States Army. After fulfilling that duty he practiced psychiatry and general medicine in Red Bank, and was affiliated with Riverview Hospital there and with

Monmouth Medical Center in Long Branch and Bayshore Hospital in Holmdel. He was active in civic affairs and currently was police surgeon for Red Bank.

Dr. Sylvester A. Choffy

On July 20, Sylvester A. Choffy, M.D., a member of our Hudson County component, died at his home in Maywood. Born at the turn of the century, Dr. Choffy earned his medical degree from New York Medical College in 1925 and practiced general medicine in the Greenville section of Jersey City until retirement in 1971. He was active in civic affairs, having been a member of several municipal authorities and medical director of the Jersey City Board of Education. Dr. Choffy was a 1975 recipient of MSNJ's Golden Merit Award indicating fifty years of medical practice.

Dr. Robert J. D'Agostini

On July 19, Robert J. D'Agostini, M.D., died at St. Michael's Medical Center, Newark, after suffering a cerebrovascular thrombosis. A native of Newark, born in 1913, Dr. D'Agostini was graduated from Georgetown University Medical School, class of 1937, and practiced general medicine in Newark for several years before devoting his attention exclusively to orthopedics. He had been affiliated with St. Michael's Medical Center and the Crippled Children's Hospital in Newark. During World War II, Dr. D'Agostini served three years with the department of medicine of the United States Army.

Dr. William X. Gebele, Jr.

Word has just been received of the death on June 6, 1976 of William X. Gebele, Jr., formerly of Lakewood. Dr. Gebele, a member of our Ocean County component, was graduated from Hahnemann Medical College in 1941, and after serving four years with the

United States Air Force practiced general medicine in Ocean County until retirement to Cape Coral, Florida in July 1975. He had been affiliated with the Paul Kimball Hospital in Lakewood. Dr. Gebele was only 60 years old at the time of his death.

Dr. Lester Siegel

One of Jersey City's well-known psychiatrists, Lester Siegel, M.D., died at his home on July 22 after a short illness. A native of Jersey City, born in 1912, Dr. Siegel was graduated from Eclectic Medical College in Cincinnati in 1936 and served a residency in psychiatry at the Jersey City Medical Center. He spent four years in the medical department of the United States Army during World War II and returned to Jersey City in 1946 for the practice of his specialty. He was chief of the psychiatric section of the Jewish Hospital in Jersey City and a member of the board of directors. He also was affiliated with Christ and Fairmount Hospitals and with the Jersey City Medical Center. Dr. Siegel was a Fellow of the American Psychiatric Association.

Dr. Leon H. S. Thomas

One of Paterson's senior physicians, Leon H. S. Thomas, M.D., died at Barnert Memorial Hospital on August 3 after a long illness. Born in Jacksonville, Florida, Dr. Thomas was graduated from Howard University Medical School in 1936 and located briefly in Jersey City and Bayonne, before coming to Paterson in 1939 where he practiced general medicine until illness forced him to curtail activities. He had been affiliated with Barnert Memorial, St. Joseph's and the Paterson General Hospitals. He was a director of New Jersey Bank, and served as physician for the Paterson Board of Education. Dr. Thomas was 70 years old at the time of his death.

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Poisoning

S. M. Marcus, M.D., et al.

Atrial Dissociation

S. K. Agarwal, M.D., et al.

Update of Rheumatic Disease

Sheldon D. Solomon, M.D.

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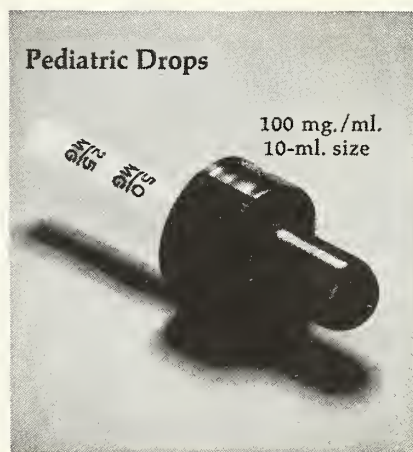
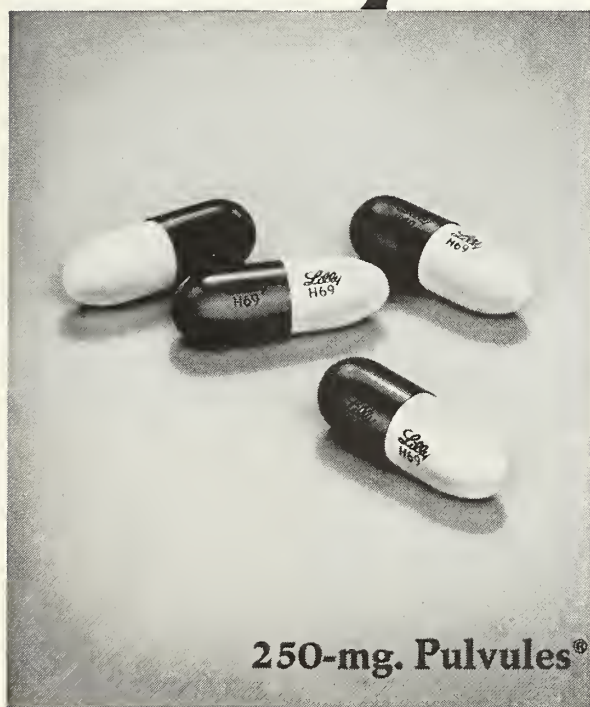
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Cover

The cover photograph of a Mochican sculpture portrait was taken by M. Jay Goodkind, M.D., who has contributed to several of our previous covers. The piece is from the collection of Dr. and Mrs. Albert Rosenthal of Trenton. (see editorial, page 821 this issue.)

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Goldwyn RM: Subcutaneous mastectomy. *J Med Soc NJ* 74:1050-1052, 1977.

Dixon WJ, Massey FJ: *Introduction to Statistical Analysis*. New York, McGraw-Hill, 1969, pp 00-00.

Accident Facts. Chicago, Illinois, National Safety Council, 1974.

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— Dr. William Felts, Past President,
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*PATIENT CARE Magazine — Outlook 1977,
"Face-Off: Cost Containment vs. Chaos,"
January 1, 1977.

Lyle CB, et al. "Practice habits in a group of
eight internists," ANNALS OF INTERNAL
MEDICINE 84 (May 1976), 594-601.

Schroeder SA, et al. "Use of laboratory tests
and pharmaceuticals: variation among
physicians and effect of cost audit on
subsequent use," JOURNAL OF THE
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(Aug. 20, 1973), 969-73.



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Emanuel M. Satulsky, M.D.—1909-1978

Emanuel M. Satulsky, M.D., 178th President of the Medical Society of New Jersey, died on Sunday, September 10, at his home in Elizabeth, after a protracted illness.

Dr. Satulsky was an alumnus of the University of Maryland, from which he received the degrees of Bachelor of Science in 1930 and Doctor of Medicine in 1934. He served his internship at Elizabeth General Hospital and engaged in postgraduate studies at New York Post-Graduate Medical School, Columbia University, and the Army Medical School, Washington, D.C.

Dr. Satulsky served in the Armed Forces from April 1941 to February 1946. The Republic of Panama, in recognition of his meritorious services, honored him with the decoration of the order of Vascos Nunez de Balboa.

In 1935, Dr. Satulsky entered the practice of medicine in Elizabeth, where he remained until his death. He was a Fellow of the American Academy of Dermatology and Syphilology, a Fellow and Past-President of the New Jersey Dermatological Society, and a Diplomate of the American Board of Dermatology and Syphilology. Through the years of his practice he maintained staff appointments and offices at Alexian Brothers Hospital, Elizabeth, Elizabeth General Hospital, and Rahway Memorial Hospital.

A life-long member and Past-President of the Union County Medical Society, Dr. Satulsky served energetically and well as a member of the House of Delegates and member and officer of the Section on Dermatology and Syphilology

of the Medical Society of New Jersey. Prior to his election to the Presidency of MSNJ in 1970, Dr. Satulsky served the Society in various capacities: as a councilor, secretary, and ultimately chairman of the Judicial Council; as member and secretary of the Board of Trustees; and as delegate to the American Medical Association.

Dr. Satulsky was keenly aware of the need for medical practitioners to face up to and meet their expanding professional and societal responsibilities. In his inaugural address he declared:

"It has been said that in the past decades there has been a great increase in expectations on the part of the public. The people expect better housing, education, environment, transportation, and health services. It has also been said that we are living in an age of unreasonable expectations, in an age of rising rash expectations, in which advances in so many fields have been made and publicized that expectations are becoming demands that do not take into consideration the complexities, the interrelationships, the scope, and the ultimate cost of the social programs that have evolved. More and more people are looking to government to supply their needs and their demands, and they are not given to distinguishing one from the other. In consequence the emerging great problem of our times is not how to create change, or how to adapt to it, but rather how to direct and control it so that it does not overwhelm us and destroy the principles and fundamentals that alone make success possible."

... that advice still seems to be apposite.

Doctor Satulsky's wife predeceased him. He is survived by his mother, his sister Ann, his son Lewis, and his daughter Linda.

Richard I. Nevin

Medicine in Art

The cover picture of this issue shows a Mochican sculpture portrait head vessel, circa A.D. 200-500, from the collection of Dr. and Mrs. Albert Rosenthal (see personal note, page 874). It clearly shows a facial paralysis and a large tumor at the base of the nose. The specimen is painted in brownish-orange and is made of clay.

Whether this double pathology represents manifestations of a single disease or multiple lesions only can be conjectured. Among the single lesions, one might consider sarcoma, encephalocele, meningioma, or gumma plus an independent seventh cranial nerve palsy. Multiple lesions in the differential diagnosis could include neurofibromatosis, metastatic malignancy with bone and meningeal deposits and sarcomatosis.¹

The Mochican culture flourished on the north coast of Peru for several centuries at the beginning of the Christian era. Their material culture was based on clay and they are renowned for their pottery, which is remarkable in its quantity, variety, and pictorial quality. Many Mochican vessels represent human figures with physical peculiarities of medical interest. Martin philosophized about medicine in art as follows:

"Man's greatest and most decisive advance was his increase of knowledge about himself, which permitted his powerful intellect to utilize the full extent of physical resources.

¹Simon E: Personal communication

"And thus, from the dawn of time, medicine has been of essential significance in all its forms and, together with the growing awareness and development of humanity, has been evolving constantly toward adapting itself to social concepts and objectives, which are unremittingly transformed according to the required results.

"Medicine is man's prime and most powerful encroachment upon his vulnerable but perfectible condition, and art is his prime and most powerful means of expressing this very condition, that is, defining the relationship to adversity, which he intends to yield to or struggle against, resorting either to exorcism or revolt.

"Inevitably, an extremely close and fruitful rapport was established at the very beginning between medicine and art. Both primitive medicine and the very first works of art, namely the ritual depictions in prehistoric caves, were products of magic. Now, after hundreds of centuries, can we be so sure that this relationship has undergone much of a change?"²

A study of the fine arts of the Mesoamerican (Mexico and parts of Guatemala and Honduras) and the Andean cultures sheds some light on medicine of the period since neither the Aztecs nor the Incas possessed any written records. The polytheistic nature of the Mesoamerican culture can be seen

²Martin AVJ: Introduction to *Medicine in Art*. New York, McGraw-Hill, 1967, p. 7.

³Ibid. p. 70

in artistic representations of human sacrifice to the gods, who, they believed, influenced health and sickness. Head and torso sculptures show cutaneous manifestations of syphilis, childbirth, facial tumors, deformities of the spine ("hunchback") presumably due to tuberculosis and typical chondrodystrophy with dwarfism. The Mochican specimens show mutilations of upper lips and nose, which appeared to have been amputated for sacred or punitive purposes. One Mochican figure shows a syphilitic mother with the typical flat nose holding her infant daughter whose body also suggests congenital syphilis. Even blindness is vividly portrayed by a fourth century Mochican pitcher.

Artistic history has shown that Barnard, Cooley, DeBakey, Shumway, and Kantrowitz were not the first cardiac transplant surgeons. The Aztecs excised the hearts of thousands of prisoners, and, while they still were pulsating, transferred them to the gods who waited in some "other-worldly empires."³

Art is a unique method for the recording of medical history. As shown by our cover, those who were intrigued by the pathology to which humans are subjected have spanned the centuries from the ancient civilizations to the present time with remarkable clarity. A.K.

Revitalized Method of Postgraduate Education

The need to keep up with current knowledge clearly is recognized by all conscientious physicians. Mechanisms for acquiring this knowledge are traditional and include reading journals and review articles, attending lectures and courses and, occasionally, participating in teaching rounds and conferences for house officers and students (if we are lucky enough to have access to such). Despite our being overly busy, most of us aggregate enough hours of postgraduate education to qualify for the medical society's recognition award.

Is there really a change in our behavior as a result of such efforts? Does our reading, listening, and rounding alter what we do with our patients? Do our students' insistent questions lead to a modification of our diagnostic or therapeutic routine? My own belief is not very much.

At a recent research meeting, a group of academicians at a "leading" medical school presented data relating to five or six studies they had conducted in their city with the participation of local physicians. These studies demonstrated that several commonly used remedies were of no value. Subsequent to the publication of these studies, another study was done to assess whether the very practitioners who had participated in the studies had stopped using the useless medicines. They found no change in the physicians' practice habits!

Several years ago another study demonstrated that some physicians were not aware of or did not react to abnormal hemoglobin levels among their hospitalized patients. Anemia was not being recognized. The staff of the hospital organized a course in hematology; a follow-up survey showed no

change. It soon became apparent that the staff physicians were not responding to the hemoglobin reports, not because they didn't know what to do, but because they did not notice them. Forcing the physicians actively to seek the hemoglobin values (by erasing the designated space on the chart) led to a significant response rate.

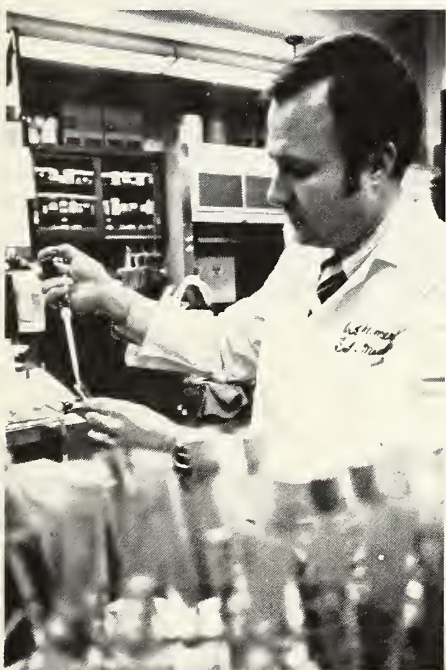
These disparate anecdotes clearly do not identify a solution. How do we keep up so that we realize that the way we have been functioning needs modification? Why are we so ready to accept new and relatively untried medicines and therapeutic modalities, yet we are loathe to stop using outworn therapies?

I don't know the answer, but *one* effective method seems to be the mini-residency concept. This is an old but recently revitalized method of continuing education in which the practitioner stops his practice for several weeks (gets coverage as for vacation) and returns to an active service in his specialty. He interreacts with the house-staff and fulltime staff by teaching them practicalities and learning the new concepts from them. The results yet have not been correlated with improved behavior (the *sine qua non* of continuing education) but it appears promising.

The medical education establishment needs prodding to expand these mini-residencies and those physicians who really want to remain current may wish to encourage their local medical educators in this direction. Since the practitioner knows his own needs best and this information, i.e., needs' assessment, is critical, he must make them known to the educators.

Richard H. Rapkin, M.D.

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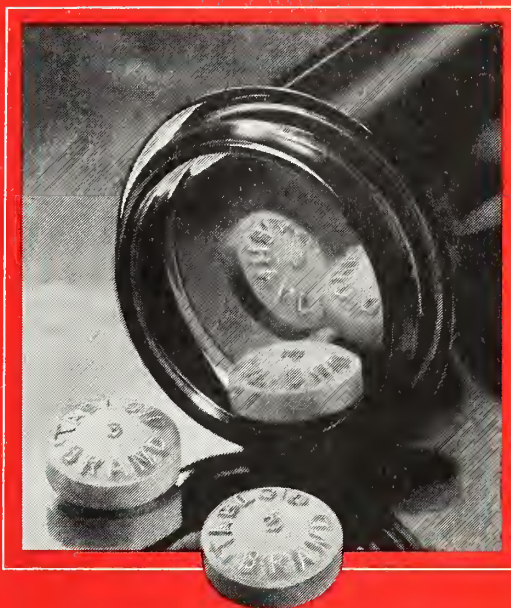
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Cerebral Death

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RICHARD E. BRENNAN, L.L.B.
GEORGE B. JACOBS, M.D.
JOHN H. HUBBARD, M.D.
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This paper surveys the medico-legal considerations attendant to a definition of death and dying. Medically, it treats the criteria for heart death as opposed to brain death. The importance of a distinction is discussed. Legally, the ramifications of determining the moment of a person's death, in the areas of real property, inheritance, and criminal law are considered. The celebrated *Quinlan* case and the removal of a decerebrate patient from artificial life-sustaining measures are discussed, together with the liability of a physician for taking these actions.

The following article explores the medical and legal dilemmas presented by the present ambivalent definition of death and discusses criteria for the diagnosis of cerebral death.

A definition of death which clearly determines its precise moment has significant implications in several areas of the law. The legal definition of death has been set forth as follows:

"The cessation of life, the ceasing to exist; defined by physicians as the total stoppage of circulation of the blood and the cessation of animal and vital consequences thereon such as respiration, pulsation, etc."¹

The Supreme Court of New Jersey in the celebrated *Quinlan* case stated:

"The determination of the fact and time of death in past years of medical science was keyed to the action of the heart and blood circulation, in turn, dependent on pulmonary activity, and hence, cessation of these functions spelled out the reality of death."⁴

Redefining death also has been prompted by recent advances in organ transplants. Transplant technology requires the acquisition of viable organs and organs are only useful if they are free from the deleterious effects of cardiovascular failure. Consequently, death defined on a cerebral basis is a practical approach that assures useful donor organs for successful transplant. The law, therefore, has to be clarified to prevent the transplant surgeon from a wrongful death

action charging him with killing what, in effect, is an already dead person.

TIME OF DEATH

The time of death is peculiarly relevant to a prosecution for homicide, or the wrongful killing of one human being by another. A charge of homicide implies that the deceased was living at the time of the mortal blow. If a comatose, persistently vegetative patient, who is being kept alive only by the use of a mechanical respirator, is assaulted or wounded and later dies, the assailant may or may not be considered guilty of homicide.

The determination of the moment of death has peculiar relevance to the above-mentioned transplantations of vital organs, especially the heart. The issue has been raised but not resolved:

"Obviously, for a heart to be transplanted to a recipient, the donor must be dead or the surgical team has committed homicide. The dilemma faced by medicine in this area is that if the surgical team is forced to wait until the donor is quite legally dead, that is, until the heart has stopped, the operation is useless."³

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The time of death may be a determination of crucial significance in the law of real property. Aside from sales of real estate, the major way in which ownership or interests in real property change is through the death of the current owner or possessor.

The question of apparent simultaneous death has been treated by a statute which has solved certain obvious problems but has raised others in determining survivorship. The "Uniform Simultaneous Death Law," adopted in almost all of the states, provides:

"Where the title of property or the devolution thereof depends upon priority of death and there is no sufficient evidence that the persons have died otherwise than simultaneously, the property of each person shall be disposed of as if he had survived. . . ."

The obvious difficulty is the provision dealing with "no sufficient evidence that the persons have died other than simultaneously. . . ." There is no difficulty where both persons are pronounced dead at the scene of a common disaster. However, where one immediately is resuscitated and the other is pronounced dead, and the one who is resuscitated is sustained thereafter mechanically but in a chronic vegetative state and later "dies," the issue of who survived or outlived whom very well may be questioned.

Frequently, a testator, or a person making a will, will direct that his property be distributed to several different individuals over several different periods of time. These future interests are known as "remainders." A precise determination of the time of death is critical in determining whether attempts to establish remainders are successful. Similarly, antilapse statutes which radically may affect the distribution of a testator's estate, also hinge upon whether a beneficiary of a will dies before the testator.

Determination of time of death also may be of crucial significance in determining who will benefit from a will because of the "Rule against Perpetuities." The "Rule against Perpetuities" draws a line at a certain period of time after a person's death beyond which he may not control his wealth. The Rule generally denies effect to any interest that a person may attempt to establish approximately 21 years after his "death." Consequently, the application of this denial may depend upon when the testator is determined to have died.

A determination of the time of death has important implications in deciding whether the statute of limitations has run and may be significant in the law of evidence. A major principle of evidence is the hearsay rule, which provides generally that out-of-court statements are not admissible at a trial. The dying declaration rule provides that in a criminal proceeding, a statement made by a victim unavailable as a witness because of his death is admissible, if it was made voluntarily and in good faith and while the declarant was conscious of his impending death. Another rule of evidence provides that a statement of a witness unavailable because of death is admissible if several similar conditions are met. Thus, the hearsay rule unjustly may bar the admission of evidence at trial if at the time of trial the dependent is dead according to one definition of death but not according to another definition.

DEFINITION OF DEATH

An accurate definition of death also has implications in the area of financial transactions and may be of importance to the disposition of jointly owned property.

An issue of great social significance arises when, in the

course of normal medical events, respiratory measures are instituted which are unsuccessful in maintaining a viable brain. How and when can these measures, that is, the respirator and pressor drugs, be discontinued?

The vaunted "Quinlan case," *In Re Karen Quinlan*,¹ did not resolve the issue of what constitutes death. The decision was grounded on the right of privacy, a right that would permit the termination of treatment to a hopelessly comatose and persistently vegetative patient. The opinion did not decide that Karen Quinlan was dead; on the contrary, it merely permitted the cessation of her unendurable life. Accordingly, the Karen Quinlan case is of limited utility in defining the time of death.

Because the heart death test, or the absence of a circulation of the blood, is inappropriate in cases of mechanically sustained respiration, many proposals have been made to adopt a modern definition of death. In some jurisdictions, legislation has provided a formal recognition of the concept of cerebral death. A prototype statute defining "brain death" as the criterion for death has been adopted in Kansas.² Similar statutes have been enacted in Maryland, Virginia, California, Alaska, New Mexico, Oklahoma, and West Virginia.

The New Jersey legislature has had cerebral death statutes under consideration. One³ provided that:

"A person shall be considered dead if in the announced opinion of a physician based on ordinary standards of medical practice, he has undergone an irreversible cessation of spontaneous respiratory and circulatory functions. In the event that artificial means of support preclude a determination that these functions have ceased, a person shall be considered dead if in the announced opinion of a physician, based on ordinary standards of medical practice, he has undergone an irreversible cessation of vital brain functions. Death will have occurred at the time when the relevant functions ceased."⁵

The purpose of that proposed legislation was to provide standards for the determination of the moment of death that are consonant with current medical thought on the subject. The accompanying Statement to the Bill⁴ provided:

"It is intended to supplant the common law definition which was based entirely on circulatory and respiratory functions by providing that where a final determination by those standards is precluded because of the use of resuscitative and supportive means, the irreversible cessation of brain functioning may be used to make the determination. Such a definition is of particular pertinence in the organ transplant situation where time is a crucial element."⁵

In addition to the bill described above, the State of New Jersey has also promulgated "Guidelines for Health Care Facilities to Implement Procedures Concerning the Care of Comatose Non-Cognitive Patients." The purpose of these Guidelines is to implement the holding of the Karen Quinlan case, mentioned above, that a committee must be formed to make the necessary critical decision respecting a vegetative patient.

It is not so much the conceptualization of brain death or irreversible coma as a diagnosis, as the criteria for making this diagnosis, which has proved difficult. The criteria had to be constructed so that a viable person never would be pronounced dead.

In 1968, "A Definition of Irreversible Coma" was published by the Ad Hoc Committee of the Harvard Medical School to examine the definition of brain death.⁶ The criteria of the Ad Hoc Committee consisted of:

1. Unreceptivity and unresponsiveness.
2. No movement or breathing.
3. No reflexes.
4. Flat electroencephalogram (EEG)—isoelectric at some point at maximal gain.
5. All of the above tests to be repeated at least 24 hours later with no change.
6. Hypothermia defined as a temperature below 32.2° centigrade.

The requirements subsequently were reduced to 12 hours of an isoelectric EEG and some hospitals reduced the requirements to one hour.⁷

Additional changes include the recognition that spinal reflexes may return and may vary on a daily basis.

In addition to the initial criteria suggested by the Harvard Ad Hoc Committee, other laboratory tests have been proposed. In their conceptual states it was hoped that perhaps one, but probably more than one test, without repetition, would provide definitive diagnostic criteria for brain death. These laboratory studies include:

1. Isoelectric EEG.
2. Arrest of blood flow at the base of the skull, demonstrated by cerebral angiography.
3. Lack of response to atropine.
4. Lack of vestibular response to caloric tests.
5. Lack of brain pulsation in echoencephalography.
6. Brain temperature lower than body temperature.
7. Intracranial pressure higher than systemic and exceeding 100 mm. Hg.
8. Oxygen consumption of brain is negligible.
9. Cessation of cerebral blood flow (determined by intracarotid injection of xenon or sodium o-iodohipurate (Hippuran®)).
10. No visualization of brain in scanning and gamma camera (performed with Technesium).
11. Lack of cerebro-spinal fluid circulation demonstrated by intrathecal injection of Radioactive Iodinated Serum Albumin (RISA).

Such studies measure different parameters of cerebral function. The EEG measures the electrical activity of the brain and is primarily a reflection of cortical neuronal activity. In a series of 25 cases meeting the clinical criteria for brain death, 25 had a flat Isoelectric EEG.⁸ The EEG is helpful in identifying patients with brain stem disease, usually infarction or hemorrhage, who might fulfill the clinical criteria of unreceptivity, unresponsiveness, apnea, and absent brain stem reflexes but with a functioning-non-expressive-cerebral cortex. There are, however, situations such as hypothermia or deep barbiturate coma which also give a flat EEG and must be distinguished from cerebral death. It is in those instances that studies demonstrating cerebral blood flow are most valuable.

The caloric vestibular test is performed by introducing ice water into the external auditory canal. The absence of tonic deviation of the eyes or nystagmus indicates destruction of vestibular-ocular pathways and also is absent in cerebral death.

The atropine test is based on a different assumption. In the presence of cerebral death, there is destruction of the intracranial parasympathetic system, the vagal activity has ceased, and therefore, the intravenous injection of 2 mgs. of atropine will cause no acceleration of the heart rate. The sympathetic nervous system with intact cell bodies in the spinal cord continues to have some function and becomes a primary determinant of cardiac rate. Therefore, the response

to isoproterenol should remain. The clinical experience has been somewhat variable.^{8,9} However, it has been reported that the intravenous administration of two mgs. of atropine produced no effects in 30 cases meeting other criteria for brain death.⁸ The atropine test is usually positive in deep coma and becomes negative with the advent of a flat EEG.

Many tests are based on the absence of intracranial blood flow and in some way measure this phenomenon. They vary in accuracy and in the complexity of the instrumentation required. Cerebral blood flow should persist in spite of a flat EEG in such conditions as hypothermia and barbiturate intoxication and some brain stem lesions. Therefore, such relatively simple studies as radionuclide angiography performed by the intravenous administration of bolus of TcPertechnetate and its detection intracranially by means of a scintillation camera should rule out the diagnosis of cerebral death secondary to barbiturates. The failure to demonstrate cerebral blood flow, at a given moment, has not been proved to be synonymous with cerebral death. This phenomenon may exist for a short period and still be reversible. Although a "no reflex" phenomenon may exist, a single determination of no intracranial filling, either angiographically or by radionuclide or oxygen consumption, although suggestive, is not definitive. This, of course, presumes a technically adequate test, such as a proper intraluminal placement of the contrast or isotope bolus, and a proper blood pressure, and so on.⁹

Some of these tests are cumbersome: measurement of cerebral brain temperature requires a craniotomy, while measurement of cerebral blood flow requires cumbersome equipment and intracarotid injection of xenon or Hippuran.⁶ Non-circulation of cerebral spinal fluid, as demonstrated by intrathecal injection of RISA, requires scanning over a prolonged period of time and is too non-specific to be valuable in the diagnosis of brain death. The obliteration of cerebral spinal fluid pathways from any cause, such as hydrocephalus or hemorrhage, can yield similar results. Despite the sophistication of the studies, it is presently suggested that they be repeated over an interval of time encompassing at least one hour in demonstrating no flow of blood or of spinal fluid.

DECISION MAKING AND LIABILITY

Certain jurisdictions, as set forth above, have opted for the cerebral death over the cardiac death test as the criterion for life. However, irrespective of the criteria for measuring the time of death, it continues to remain a medical decision. Note the proposed New Jersey statute which was couched in terms of "ordinary standards of medical practice." The criteria for the diagnosis are left to the medical profession. Indeed, the Uniform Anatomical Gift Act, adopted by most jurisdictions, merely begs the question of the determination of the moment of death. It provides:

"The true time of death shall be determined by a physician who tends the donor at his death or, if none, the physician who certifies the death. The physician shall not participate in the procedure for removing or transplanting a part."

It now seems that the diagnosis requires a combination of clinical findings which include unresponsive coma, apnea, unreactive dilated pupils, absent brain stem reflexes, such as oculocephalic, corneal, and vestibular. Additional laboratory studies, including at least an isoelectric EEG and perhaps some index of absent cerebral blood flow are confirmatory. Persistence of clinical findings and an isoelectric EEG for more than three hours should establish the diagnosis. In the

presence of drug intoxication, indicators of cerebral blood flow are most helpful.

Despite the recognition of cerebral death as opposed to cardiac death and the availability of a workable set of criteria to make this diagnosis, it should be remembered that cardiovascular collapse shortly will follow cerebral death. The distinction is only meaningful when the acquisition of organs, legal ramifications, or economic costs are involved. Those instances of prolonged survival without meaningful cerebral function and without an optimistic prognosis, such as the case of Karen Quinlan, often do not meet the criteria for cerebral death. Such cases require individual analysis and subsequent judicial or legislative guidelines. It is probable that the outcome of such cases will be determined along guidelines relating to the patient's and the family's right to privacy. This will involve the right to consent to further care and considerations of what constitutes ordinary and what constitutes extraordinary care.

Paramount to the issues is the question of who is to make the decision. The doctor, family, or collegiate groups, such as an "Ethics Committee" all may be involved.

Of obvious concern to every physician faced with a persistently vegetative patient who is being kept alive mechanically is the potential criminal and civil liability for terminating the life support systems. Civil liability, if it existed, would be manifested in a judgment that a physician caused the "wrongful death" of the patient and the measure of damages would be the pecuniary or monetary loss to the survivors. Criminal liability, if it existed, would take the form of a judgment that the physician was guilty of homicide: i.e., murder or the varying degrees of manslaughter.

A civil action for wrongful death would be premised on the proposition that a physician committed malpractice—a negligent deviation from standard and accepted practice—or upon the proposition that he intentionally caused the patient's death by withdrawing the supportive therapy. Criminal liability would be based on the necessary finding that the doctor had the intent to kill his patient.

If the brain death test is accepted as the criterion for the determination of death, it would be difficult to sustain a civil action for wrongful death or a criminal indictment for homicide against a physician who terminates supportive measures on a patient who has undergone an irreversible cessation of spontaneous respiratory and circulatory functions. In the criminal field, one observer has addressed this issue in terms of euthanasia:

"The importance of these statutes (brain death criteria) to the physician in respect to the euthanasia situation is significant. If the patient's EEG is no longer active, indicating a cessation of brain functioning, the patient may be pronounced legally dead, even though his heart is still beating. In this situation, the physician who unplugs the patient's respirator (which may be allowing his heart and lungs to continue functioning) and thereby hasten death, will escape criminal liability for his actions."¹⁰

Without a brain-death set of statutory criteria, criminal liability possibly may exist when a physician fails to take extraordinary measures to support life. Ordinary measures have been said to be those which offer a reasonable hope of benefit and which can be obtained and used without excessive expense, pain, or other inconvenience. Extraordinary measures are considered to be those which do not involve these factors or which, if used, would offer no reasonable hope of benefit.¹¹

The nationally prominent criminal lawyer, Percy Fore-

man, has addressed himself to this issue:

"The distinction between involuntary euthanasia by a positive act and involuntary euthanasia by omission is not always easy to discern. Suppose a patient is alive only because he is connected to a mechanical respirator. Without the machine, he would die. Attempts are made by the physician to revive him to a self-sufficient state, while the machine artificially keeps him breathing. After a period of time, the doctor concludes his efforts are futile and decides to unplug the machine. The patient dies. Is the doctor's act of unplugging the life-supporting machine an 'external manifestation of the doctor's will,' that is a positive act? Or is the act to be considered an omission by the doctor in that he is omitting to provide further lifesaving medical care? If it is an affirmative act, and without the patient's consent, theoretically, the doctor would be liable for murder. On the other hand, if it is deemed an omission, then the criminal liability of the doctor would turn on the question of duty. Although the doctor has a duty to administer ordinary means to preserve life, there is not a duty to administer 'extraordinary' means."¹²

In a state that retains the heart-death criterion for death, a person is legally alive if his heartbeat and respiration continue by artificial means, even though his electroencephalogram may reflect an isoelectric or flat wave pattern over a period of time.

In the area of civil liability, the Karen Quinlan case is of significance. The Court appointed Karen's father to be her guardian and authorized him to disconnect her respirator if (a) the family concurred in the decision, (b) the attending physician concluded that there was no reasonable expectation of her recovery and (c) a hospital "Ethics Committee" agreed with the grim prognosis.

With respect to a deviation from accepted medical standards—the keystone of liability for malpractice—the Court specifically made note of the fact that physicians do not artificially breathe terminal patients where this would be of no benefit. In eschewing the fastening of liability on a physician under the circumstances presented, the Court wrote:

"If that consultative body (Ethics Committee) agrees that there is no reasonable possibility of Karen's ever emerging from her present comatose condition to a cognitive, sapient state, the present life-support system may be withdrawn and said action shall be without any civil liability therefor, on the part of any participant, whether guardian, physician, hospital or other."¹²

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^aThis 1975 Bill was not acted upon. A similar Bill (S-33) was introduced in the 1978 Legislature—Editor.

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Reflections on Rhinoplasty*

FRED J. STUCKER, JR., M.D., Philadelphia

Rhinoplasty, one of the most common elective surgical procedures, has potential for good as well as harm. The need for preoperative psychological evaluation is emphasized. Successful aspects of surgical technique are described.

The rhinoplasty represents one of the most complicated procedures performed by the otolaryngologist. The variables of esthetic and functional nasal surgery may appear to be in conflict and thus compromise a successful outcome. With rare exceptions cosmetic and functional corrective nasal surgery are best combined to assure an optimum result.

Basic to nasal surgery are a patient's desire for correction of a deformity and a surgeon possessing the skills necessary for the reconstruction. Practically, the importance of a psychologically suited patient cannot be overstated. The results of a rhinoplasty are displayed so prominently that preoperatively the expected success must be weighed carefully in relation to the general indications for surgery.

PSYCHOLOGICAL SUITABILITY

A psychologic assessment is an integral part of the preoperative evaluation of all rhinoplasty candidates. Psychiatric problems resulting from cosmetic nasal surgery are infrequent but in my experience those that do occur are catastrophes. I had personal experience with two such cases in over three thousand rhinoplasties. Both of my patients became severely depressed and suicidal and required intensive therapy and support for approximately three months. Despite an excellent cosmetic result they were overwhelmed by the surgical stress and unable to cope. (Figure 1)

Refusing surgery to those with a greater risk for failure

while not depriving the great number who would benefit is the crux of determining suitability. Most experienced rhinoplasty surgeons use an intuitive rather than pragmatic screening process.

There are few absolute criteria for disqualifications other than the obvious inability to improve the patient with surgery. Some guidelines for predicting the unfavorable result are worthy of mention. The patient with a minimal defect or an inordinate disturbance for the degree of deformity should be scheduled for surgery only after carefully evaluating all other factors. Candidates who are unable clearly to articulate the change desired have high potential for failure. Those with previous cosmetic surgical failure or those highly critical of other surgeons best are avoided lest they add your name to their list. Obvious psychiatric disturbances are not necessarily disqualifying, but working in concert with a psychiatrist is essential.

As essential for success as the technical aspects of surgery is patient-doctor rapport. Patient satisfaction is much more likely if a harmonious relationship is present.

TECHNICAL CONSIDERATION

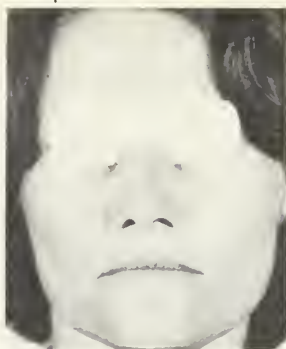
Experience disposes surgeons to favor techniques which

*Presented at the Annual Fall Meeting of the New Jersey Academy of Ophthalmology and Otolaryngology, November 16, 1977. Dr. Stucker is Chairman, Department of Otolaryngology and Maxillofacial Surgery, Naval Regional Medical Center, Philadelphia, 19145. He may be addressed there.

Preoperative



Postoperative



Preoperative



Postoperative



Figure 1 — Pre and nine-months postoperative photographs of patient who became severely depressed following rhinoplasty.

yield consistently good results for them. Anatomical variables and surgical preferences preclude the universal acceptance of any one procedure. This manuscript presents some of the technical details and suggestions which the author has found to be successful in his hands.

Anesthesia—Local infiltration is utilized for all septorhinoplasty procedures. Adequate preoperative sedation and supplemental intravenous Valium® permit the use of as little as five to seven cc of the local agent for complete anesthesia. One must guard against copious infiltration which balloons and distorts the tissues compromising the precise handling of the fine nasal structure. After completing the local injection hemostasis is enhanced by delaying surgery for ten minutes.

INCISIONS AND NASAL LOBULE SURGERY

Altering the nasal tip can be accomplished by cartilage splitting, delivery and retrograde techniques. Because most surgeons prefer to manage the tip cartilage as the initial step in rhinoplasty the intercartilagenous or cartilage splitting incision is the logical opening incision.

The **cartilage splitting** incision is placed along the proposed resection of the alar cartilage's lateral crura. The mucosa is incised sharply and separated from the cartilage above using a spreading action with a curved iris scissors. The cartilage is incised preserving a three to five mm caudal strip. Resection of the rostral portion of the lateral crura follows after freeing it from the overlying skin. Retrograde surgery allows further modification.

An **intercartilage incision** separates the lateral crus of the alar cartilage from the upper lateral cartilage. A **subsequent marginal incision** along the inferior aspect of the lower lateral cartilage permits the caudal delivery of the bipedicle flap of the alar cartilage. The tip cartilage then is trimmed or excised under direct vision.

Retrograde excisions can be done after either an intercartilage or intracartilage incision. This technique is less precise than the delivery approach and requires considerable surgical judgment.

Soft tissue elevation over the dorsum is readily accomplished through either the intercartilage or cartilage-splitting incision. Sharp dissection is less traumatic but the use of double-edged scissors is perhaps safer. It is wise to elevate the periosteum more completely to mask minor defects of the bony dorsum created by rhinoplasty.

A **transfixion incision** of the membranous septum which hugs the caudal septum, completes either the limen vestibular or intracartilage incision. This incision does not describe the usual arc but forms a sharp angle where the cartilage splitting or intercartilage incision and the transfixion

meet. The inferior extension stops short of disrupting the feet of the medial crura as they straddle the septum. Access to the premaxilla for purposes of freeing the depressor septi muscle, resection of the anterior nasal spine, or placement of plumping grafts, is done easily without violating the mucosa or vestibular skin.

FACTOR INFLUENCING THE CHOICE OF TECHNIQUE

The decision to utilize a particular technique in rhinoplasty is based upon the operator's experience and the deformities to be corrected. Every incision creates a defect which we hope is more minor than the deformity it corrects. Therefore, it is prudent to balance the potential gain against the disadvantages before an incision is made. Reducing the number of intranasal incisions results in fewer unpredictable postoperative distortions.

Techniques which advocate delivery of the alar cartilages are favored by a majority of rhinoplastic surgeons. Intercartilage separations and marginal incisions are followed by freeing the dorsal soft tissue and intercrural attachments of the lower lateral cartilage. The bipedical chondromucosal flap is delivered inferiorly where critical sculpturing of cartilage is possible. This technique is utilized in asymmetric, bifid, ptotic and excessively projected tips. Softening or shaving cut edges of the alar cartilage is possible and is especially important in those patients with very thin skin.

The cartilage-splitting technique is favored by the author in corrective nasal surgery not specifically directed at recontouring the basic size and shape of the tip. This situation is rather common in rhinoplasties in men with a basically good lobule and somewhat thick skin. A smaller percentage of females also readily are adapted to this expeditious method.

A transfixion incision often is incriminated as the cause of postoperative tip ptosis. A droopy tip is an attendant of aging which can be aggravated by the contraction of a linear membranous septum scar. A transfixion incision benefits the procedure intended to decrease tip projection. Correction of deformities involving the caudal septum which include most C and S-shaped defects requires exposure through a transfixion incision. As previously mentioned the incision through the membranous septum routinely is not carried inferiorly beyond the feet of the mesial crura. A septal mucosal flap is developed by the unilateral extension of the transfixion incision cephalad and inferiorly onto the floor of the nose. This enables complete elevation of a mucoperichondrial and mucoperiosteal flap and subsequent septal management. Unless there is a definite indication for its use the transfixion incision is eliminated.

Resection of Bony and Cartilage Dorsum is accomplished

under direct vision retracting the overlying soft tissues with an Aufrecht retractor. The dorsal cartilage is lowered with a knife usually without cutting through the endonasal mucosa. Strips of cartilage are removed until the desired lowering is achieved. Downward digital pressure at the base of the columella is an excellent maneuver to indicate the actual dorsal cartilage profile. It often demonstrates the need for furthering resection of cartilage. Failure adequately to lower the cartilaginous dorsum results in the unsightly postoperative "Polly Beak."

The amount of bony hump removal is fixed by the dorsal cartilage resection. The instruments preferred by the author for hump removal are a chisel or Kazanjian forceps. A rasp is used for minor bony deformities or refinement after the major bony hump is resected. More than 80 percent of our patients possess an acceptable nasofrontal angle and a pleasing narrow intercanthal area. Violating this area in most patients with surgical trauma is unwise. Those patients who require deepening of the nasofrontal angle or narrowing of the nose in the intercanthal region require special attention. The bone forceps cannot be used to remove the hump and deepen the nasofrontal angle. A continuous chisel cut removing the bony hump and creating a sharper nasofrontal angle is the author's preferred technique. Narrowing is often described as occurring after removal of central wedges of solid bone. This method never has been successful for me. I prefer to narrow the solid lateral walls with a chisel, rasp, or bone forceps. Prior to any osseous work in the nasofrontal angle fastidious elevation of the periosteum is important. Avulsion of the procerus muscle is condemned as nugatory, yielding unacceptable short-term swelling and little long-term improvement.

Osteotomies. Medical osteotomies theoretically are completed in those cases where significant bony hump is removed. A curved six mm chisel is used effectively for routine medial osteotomies. The chisel is directed superolateral along the intended fracture line and avoids creating the so-called rocker formation. This technique also assures that a deflected perpendicular plate will not route both medial osteotomies to one side.

Lateral osteotomies allow mobilization and narrowing of the lateral nasal walls. I employ a two or three mm chisel to produce a continuous lateral osteotomy. The chisel is pushed through the mucosa starting the osteotomy approximately 0.6 cm superior to the most lateral aspect of the pyriform aperture. The osteome is advanced without periosteal elevation with a mallet in a superolateral direction until the nasomaxillary groove is encountered. The chisel is repositioned and driven in a superomedial direction angling more medial as the osteotomy is completed. The narrow chisel cuts the bone with minimal disruption of the investing periosteum and soft tissue. This technique minimizes the chance of lateral wall collapse or excessive narrowing compromising the airway. This is attributed to periosteal attach-

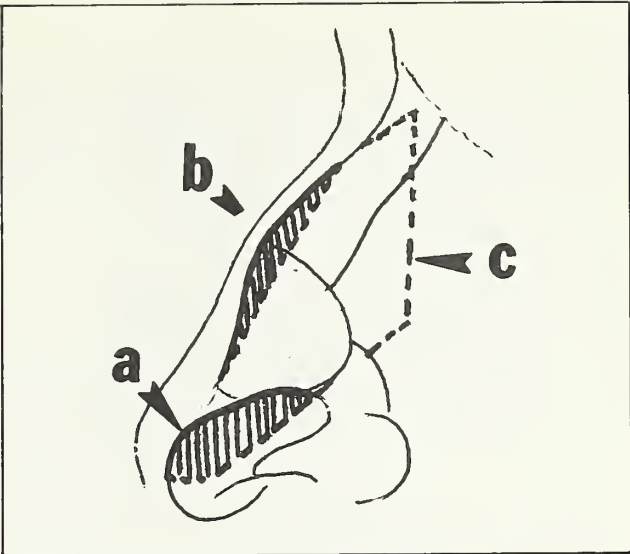


Figure 2 — Basic technical maneuvers in a rhinoplasty:
(a) Resected rostral portion of lower lateral cartilages
(b) Cartilage and bony hump removal
(c) Line of lateral osteotomy

ments and an intact bony strut with its fibrous attachments to the upper lateral cartilage preventing pinching in the valve area. (Figure 2)

Sutures, Splints and Postoperative Routine. The cartilage-splitting and transfixion incisions are closed with a running 5-0 chromic suture. The sharp angle created at the junction of the mucosal incision prevents malpositioning of the flaps. The intercartilage and marginal incision are closed with interrupted 5-0 chromic sutures.

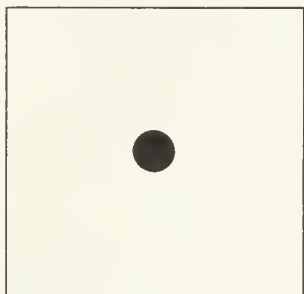
The nose is splinted for five to six days with paper tape after adhesive is sprayed on the nose. Plaster is fashioned to the proper size and applied wet to the taped nose. The cast is held approximately three minutes until set. Intranasal packing is routinely avoided. Steroids, antibiotics, enzymes, or other anti-inflammatory agents routinely are not employed. Ice packs or compression dressing to the eyes are not utilized. The patients are instructed to maintain head elevations for the first 48 hours postoperatively.

SUMMARY

The rhinoplasty is one of the most common elective surgical procedures. It has great potential for good as well as harm. A psychologic cataclysm is very uncommon but devastating when encountered. For this reason high-risk patients best are denied surgery.

The choice of a technical procedure is guided by the presenting deformity and the operator's experience. The truly successful surgeon achieves excellence by unusual technical competence and the ability to achieve excellent patient rapport.

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DESCRIPTION: Methyltestosterone is 17 β -Hydroxy-17-Methylandro-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric,

avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE**

REACTIONS: Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunichism, 10 to 40 mg; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg. Postpuberal cryptorchidism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahoglu, M.D.: Hormones for Improved Sexuality in the Male and the Female Climacteric. *Drug Therapy*, Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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Mouthing Activities and Their Relationship to Lead Poisoning*

STEVEN M. MARCUS, M.D.
RHODORA DAMASO-DIAZ, M.D.
ROBERT ZIERING, M.D., Newark

A study was performed to relate the age at weaning from the bottle with the development of lead poisoning. A highly significant relationship was found between late weaning, pica, and lead poisoning. This suggests a possible preventative approach to the problem of childhood lead poisoning.

We have observed in the Pediatric Lead Clinic at Newark Beth Israel Medical Center, (NBIMC), what seems to be an inordinate percentage of children over the age of two years still drinking from nursing bottles. This study was designed to determine if a relationship exists between delayed weaning, pica, and lead poisoning.

METHODS

Two hundred consecutive children seen in the lead clinic originally were included in the study population. Fifty were eliminated because of incomplete data collection. The remaining 150 children, representing 10 percent of the known patients at the lead clinic at NBIMC, were interviewed.

Each patient had three or more lead tests performed in the six months prior to the interview. Lead levels were performed using an atomic absorption spectrometer in a laboratory which participated in the Center for Disease Control Lead Analysis Proficiency Study.

A questionnaire was filled out either by a pediatric resident or nurse prior to reviewing patients' charts. The personnel were instructed to ask the following questions:

1. At what age did your child give up the bottle? (This must include naptime and night bottles)
2. Does your child put things other than food into his mouth? Does he do this regularly?

Efforts were made through in-service training of study personnel to assure the use of the standardized questions to

eliminate bias due to interviewing techniques.

Upon completion of the clinic visit, a chart review was undertaken. The first lead test, the highest and the level at that visit all were recorded.

RESULTS

Weaning: A significant rise in the incidence of screening levels of over 50 g/dl was found as the age at weaning increased. This rise was significant at < 0.01 (by chi square).

Pica: No correlation was found between the presence of pica and the highest level of lead found in chart review or in screening levels:

Table 1				
		Pica	No Pica	% Pica
Pb	≥50	50	20	71
	45-49	23	10	70
	40-44	13	7	65
	35-39	7	8	47
	30-34	6	3	67
	<29	3	1	75

Pica and Late Weaning: A statistically significant relationship was demonstrated between delayed weaning (> 24 months) and pica ($p < 0.01$):

*From the Department of Pediatrics, Newark Beth Israel Medical Center, where Dr. Marcus is assistant director. Correspondence may be addressed to him there, 201 Lyons Avenue, Newark 07112.

Table 2

Age at Weaning	Pica	No Pica	% Pica
≥ 24 mos.	58	37	61
24-30 mos.	26	8	76
<30 mos.	15	4	79

DISCUSSION

Pica, the term used to describe the unnatural craving to eat non-food substances, was described in the sixth century, associated with pregnancy,¹ but not recognized as a phenomenon of childhood until the 16th century.

The overall incidence of pica in our study population approximated that found in the studies of de la Burde.² Although both populations may be selected groups, the similarity of the findings suggests that pica is not an unusual phenomenon. Pica may be a natural event which persists or it may be symptomatic of an endemic phenomenon.

We have demonstrated a relationship between the age at weaning and pica. Galt³ described pica in children of the upper Amazon who developed the "habit" after a long period of sucking. Gros¹ also described pica as a phenomenon associated with a delay in weaning. The attitude of complacency toward weaning in our population is also shown in Salk's book for parents.⁴ He suggests that a child should not be weaned early, but should be allowed to drink from a bottle "until he is ready" to be weaned. No advice is offered as to how to determine the most appropriate time.

We also found a significantly higher screening lead level in late-weaned children although we were unable to document a positive relationship between pica and lead levels. This may be due to the small number of children with lead levels less than 30, an artificial cutoff point suggested by the Center for Disease Control (CDC) as diagnostic of increased lead absorption. It would be unlikely that it is due to differences in exposure since 80 percent of the housing units in Newark are contaminated by lead.

These findings suggest that a method of primary prevention of lead poisoning may be to advise parents to attempt weaning at an age where pica and lead poisoning will be less likely. Our study does not pinpoint such an age. It does suggest that the mechanism which associates delayed weaning and lead poisoning already is established by two years of age. Discussions with parents regarding the potential danger of late weaning should be part of well-child supervision.

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Bronchial Asthma

Part I: Diagnosis*

MICHAEL S. MATTIKOW, M.D., Wayne
FREDRIC A. SCHULANER, M.D., Westfield

The diagnosis of bronchial asthma depends on a careful history, physical examination, and selected laboratory and skin tests. In the differential diagnosis of difficult problems, x-ray studies and endoscopy may be necessary.

Asthma is a condition causing widespread misery physically, socially, and economically.¹ In a series of three papers, we will give the clinician a practical approach to the diagnosis, office management, and hospital treatment of this condition. But first we must define what we mean by asthma. For the ancients, it meant some form of difficulty breathing, mostly episodic.

"If from running, gymnastic exercises or any other work, the breathing becomes difficult, it is called asthma, and the disease orthopnea is also called asthma, for in the paroxysms the patients also pant for breath."^a

Today, we consider asthma a disease characterized by an increased response of the trachea and bronchi to various stimuli, manifested by widespread narrowing of the airways and changes in severity, either spontaneously or as the result of therapy.² In other words, there must be an element of reversibility. The narrowing of the airways is due to edema of the mucosa, spasm of the smooth muscle of the bronchial tree, and excess mucous production, which, along with cellular debris, eventually can plug the narrow airways.

There are two points that deserve emphasis to understand the disease better. The first is the increased responsiveness of the bronchial tree to a host of chemical, infectious, immunological, physical, and emotional factors in asthmatics.³ These are the triggering agents for the asthmatic patient

which will initiate or exacerbate the wheezing, cough, and dyspnea. The second is the reversibility.

TRIGGERING AGENTS

What are the factors which react with the hyper-responsive bronchial tree of the asthmatic? Usually, they are divided into non-allergic and allergic triggering agents. Table I is a list of the most important of these non-allergic triggering agents, which will be discussed in greater detail in the following paragraphs.

Infections, especially viral respiratory infections, are among the most common precipitating causes of wheezing, often producing severe attacks that require hospitalization.⁴ The mechanism by which infections trigger bronchospasm is not clear, but most likely it is due to their direct invasion of the respiratory mucosa with ensuing inflammation. Provocation of asthma also may possibly occur via the parasympathetic system with reflex bronchoconstriction.

Exercise is probably the most common factor triggering wheezing spells. Apparently if any asthmatic exercises long and hard enough, he or she will wheeze. Just how much exercise it takes to cause symptoms is a good measure of how severe the asthma is. Exercise-induced asthma has been intensively studied, but its precise mechanism of action is not known. It is most likely due to release of chemical mediators.

*This is the first in a series of three papers from the New Jersey Allergy Society on the modern approach to diagnosis, office management, and hospital care of the asthmatic.

^a from Aretaeus the Cappadocian, 2nd Century A.D.

In almost all cases, asthma can be prevented by giving a bronchodilator prior to the exercise.

Table I
Non-Allergic Triggering Factors

- Infection
- Exercise
- Emotions
- Cold Air
- Tobacco Smoke
- Aspirin
- Pollution
- Local aero-irritants

Emotions can trigger asthma, but they very rarely are the only factor involved. Anger and excitement are probably the most important emotions triggering such attacks. Laughter can also cause wheezing, and its mechanism seems to be similar to that of exercise-induced asthma.

Cold air is a very important stimulator of wheezing, especially when combined with exertion. It is due to reflex vagal stimulation from sensory fibers in the skin of the face and oral pharynx.⁵

Tobacco smoke is also a very important and preventable trigger in asthma. Not only is the smoker affected, but those in his immediate environment are as well. It has been well demonstrated that children living in homes where either of the parents smokes, will wheeze continually, despite intensive medication, until the smoking is discontinued. The actual mechanism is probably not allergic in nature.

How *aspirin* and other non-steroidal anti-inflammatory agents precipitate wheezing is not entirely clear, although it is not on an allergic basis. In many groups of asthmatics studied, up to twenty percent will have an exacerbation following the use of aspirin.⁶

There is no doubt that *air pollution* can aggravate bronchial asthma, although it may be difficult to recognize the individual instance. Historically, in severe episodes of pollution, such as occurred in Donora, Pennsylvania, London, and New Orleans, most asthmatics were affected. Using daily fluctuations of various air pollution indicators, it has been found that when there was a significant increase in these indicators, more patients were seen in the emergency room for treatment of asthmatic attacks. There was greater frequency in emergency room visits when there was an associated high pressure inversion.⁷ The longer the inversion lasted, the worse the situation became.

Local *aero-irritants* can have a profound effect upon the asthmatic. These include perfumes, hair sprays, insecticides, cooking odors, and especially chemical fumes which can cause severe and prolonged wheezing attacks.

The effect on the individual patient upon exposure to these factors is variable. For example, one patient may have extreme sensitivity to chemical fumes, but less to exertion or to infection. Another may react to weather changes, but less so to emotional stress. These trigger factors are considered *intrinsic*, and it is important for the proper care of these patients to learn which are their major precipitating factors.

Other patients have inherited the ability to produce antibodies of the I E class upon exposure to common substances encountered in their environment, call *extrinsic* factors. Re-exposure to these substances or allergens may cause bronchospasm.

Knowing something about the common allergens can be of great help in both diagnosing and treating such patients.

Table II lists the common allergens that can precipitate asthma.

Table II
Allergic Triggering Factors

- Inhalants
- Pollens: Trees
- Grosses
- Rogweed
- Mold Spores
- Foods

The common indoor inhalants—house dust, wool, animal danders, feathers, and in certain areas, cockroaches, can be associated with perennial wheezing. Those sensitive to animal dander can have severe, prolonged asthmatic attacks. One should ask about symptoms relating to exposure to these substances in the home. Avoidance is the treatment of choice, of course, in the allergic asthmatic, although it is not completely possible in all cases.

Those patients whose asthma is related to pollen will give a history of definite seasonal exacerbations. Depending on local conditions, trees begin to pollinate in late March and continue through June. However, patients can be sensitive to one species, and not another, so some may have early symptoms if they are sensitive to maple or elm and late symptoms if they are allergic to oak. In North Jersey, this is a very common cause of seasonal wheezing. Patients sensitive to one grass in this part of the country are also sensitive to other species. Pollination generally begins in May, reaching a peak in June and continuing through early July. Ragweed begins to pollinate in mid-August and continues until early October. However, many patients are also allergic to dust and some to mold spores, so often they do not stop wheezing when pollination ceases, but continue through the fall.

Allergy to mold spores is not as easily recognizable as pollen sensitivity. Some mold spores such as alternaria or hormodendrum are primarily airborne. They are found in the atmosphere in early spring and, depending upon local conditions, continue until the ground is frozen. One should always suspect mold allergy if seasonal symptoms are prolonged and if there is no mid-summer break as there would be in the multiple-pollen sensitive patient. Other molds, such as penicillium or aspergillus can be found indoors under the proper circumstances. There will be no definite seasonal pattern in these patients. Skin testing and environmental history are of great help in diagnosis. Asking about situations where there can be mold contamination of the home may be useful. For example, wet basements, humidifiers, unit air conditioners, indoor plants, and obvious mold contamination of walls may be the source of the patient's problem. Mold plates placed in various rooms in the home can be of help if no obvious source is found.

Foods are not a common cause of wheezing in adults, but are certainly a factor in infants and young children. Especially important are milk, corn, peanuts, and chocolate. One should suspect food sensitivity in younger patients who have chronic, non-seasonal wheezing and coughing.

Another class of *extrinsic* asthma is *industrial* asthma. It is interesting that industrial asthma can occur in the non-allergic patient through mediation by IgG class antibodies rather than IgE. An example of IgE mediated asthma is the patient with "Baker's Asthma." Those working with wheat and other grains may wheeze upon exposure to grain dust,

but not when eating the grains as food. Similar occupational problems have occurred with those working with coffee beans, cottonseed, and the enzymes used for detergents.

REVERSIBILITY

Returning to our original definition of bronchial asthma, in addition to the increased responsiveness of the bronchial tree to triggers, the second point is worth emphasizing. That is the reversibility of the bronchospasm.⁸ This reversibility should be established either by history, observation, or if the wheezing is persistent, by therapeutic maneuvers, confirmed with pulmonary function testing. Most of the diseases that can be confused with bronchial asthma do not have this significant degree of reversibility. A patient presenting to one's office or seen in the emergency room with wheezing type of respiration, should not be diagnosed automatically as bronchial asthma.

Table III is a list of some of those conditions occurring in infants and children that may be confused with bronchial asthma.

Table III
Differential Diagnosis of Asthma
in Infants and Children

- 1. Foreign body
- 2. Obstruction larynx, tracheo, main bronchi
 - Inflammation
 - Croup
 - Laryngotracheobronchitis
 - Epiglottitis
 - Tumors
 - Congenital Anomalies
 - Trocheomalacia
 - Floccid epiglottis
- 3. Obstruction of the lower respiratory tract
 - Inflammation
 - "Asthmatic bronchitis"
 - Bronchiolitis
 - Pneumonitis
 - Tumors
 - Congenital Anomalies
 - Cystic Fibrosis
- 4. Aspiration

Foreign body in the upper airway will cause immediate and severe respiratory distress, while that below the level of the trachea will have more chronic symptoms, with wheezing that may be generalized. Not all foreign bodies are radio-opaque, therefore bronchoscopy is indicated if such a diagnosis is suspected.

Obstructions of the larynx, trachea, and large bronchi, whether due to inflammation, tumor, or congenital anomaly, characteristically will cause inspiratory stridor, with an absence of expiratory wheeze. This will help point to the proper diagnosis. In tumors and congenital anomalies, there should be little fluctuation of symptoms or physical findings.

Infections of the lower respiratory tract, if associated with wheezing, certainly can be confused with bronchial asthma. If recurrent, underlying abnormalities—such as anatomical defects, immunoglobulin deficiencies, as well as allergic diathesis, should be considered. Right middle lobe atelectasis creates a special problem. Obstruction for any reason will act as an irritant and cause wheezing, but the most common etiology today of right middle lobe atelectasis is bronchial asthma. The inflammatory obstruction of the bronchioles in bronchiolitis certainly can be confused with

asthma. From one-third to one-half of such patients diagnosed with bronchiolitis develop true bronchial asthma in later years. Therefore, if the patient presents with a second or third bout of "bronchiolitis," suspect bronchial asthma. Any child who has recurrent pneumonias, especially if associated with gastrointestinal symptoms, failure to thrive, as well as a history of sinusitis or nasal polyp, should have a sweat test, to rule out cystic fibrosis.

Aspiration in infants and young children due to gastro-esophageal reflux is being investigated at this time as a possible cause of recurrent wheezing or bronchitis and may be more common than formerly believed.⁹

DIFFERENTIAL DIAGNOSIS

In Table IV are those conditions in adults that should be considered in a differential diagnosis of asthma.

Table IV
Differential Diagnosis of Asthma in Adults

- 1. Pulmonary embolism
- 2. Cardiac asthma
- 3. Central airway obstruction — Extra and Intrathoracic
- 4. Angio-edema
- 5. Pulmonary aspiation
- 6. Carcinoid syndrome
- 7. Environmental toxins
- 8. Psychogenic illness
- 9. Pulmonary infiltration with eosinophilia (PIE)

Pulmonary emboli may be confused with bronchial asthma. Wheezing and dyspnea may be present and the laboratory findings may be similar. Predisposing factors such as congenital heart disease, thrombophlebitis, immobilization, pregnancy, varicose veins, and the use of oral contraceptives are important clues in suspecting the diagnosis. Chest pain and hemoptysis are common in pulmonary emboli, but are uncommon in bronchial asthma. Unfortunately, radio-active albumin lung scans can be abnormal in both conditions, and the classical x-ray findings of pulmonary emboli may not be present. In a situation where the distinction is impossible, a pulmonary arteriogram may be necessary.

Cardiac asthma is left ventricular failure manifested in the lung by wheezing and dyspnea. Of course, the cardiac findings of congestive heart failure would be rare in asthma. In the emergency situation, when faced with a patient with severe dyspnea, orthopnea, with inspiratory and expiratory wheezing, the distinction may be difficult.

The larger airways can be obstructed by compression from outside the thorax by an enlarged thyroid, lymphoma, or other tumors. Intra-thoracic obstruction can be due to strictures, tumors, and foreign bodies. Extra-thoracic obstruction will produce inspiratory wheezes and stridor, while those with intra-thoracic obstruction will cause expiratory wheezing which characteristically is persistent and localized, and which is not typical of bronchial asthma. The chest x-ray is usually abnormal in these cases.

Angio-edema frequently involves the laryngeal area while other sites may not be involved at the same time. Symptoms of inspiratory obstruction are present. The hereditary type can be diagnosed by enzyme studies such as C₁ esterase inhibitor.

Aspiration is not uncommon in adults, especially the elderly, debilitated, alcoholic, and postoperative patients. Hiatal hernia, with gastro-esophageal reflux can produce pulmonary aspiration, with chronic cough and wheeze without any accompanying gastro-intestinal symptoms.

Carcinoid syndrome consists of paroxysmal episodes of flushing, chronic watery diarrhea, wheezing, and hypotension. If a wheeze is prominent, there may be some confusion with bronchial asthma, especially as it is episodic and can be controlled with steroids. However, flushing is usually present if there are pulmonary symptoms. Diagnosis is established by finding elevated levels of 5 hydroxy indole acetic acid which is released by the carcinoid tumors.

Environmental and industrial toxins can cause wheezing in any individual if exposure is great enough. Common examples are the fumes of ammonia, nitrogen dioxide, sulphur dioxide, and chlorine. As mentioned before, some patients develop true immunologically mediated bronchial asthma from exposure to chemical and other antigens related to their employment.

Patients with *neurocirculatory asthenia, or hyperventilation syndrome*, will complain of respiratory distress, especially the inability to take a deep breath. Of course these patients will have no evidence of airway obstruction either by physical examination or pulmonary function testing.

Pulmonary infiltration with eosinophilia (PIE) syndrome represents a whole group of illnesses that share the common denominator of pulmonary infiltrate with peripheral blood eosinophilia, and wheezing. They include such entities as Loeffler's syndrome, aspergillosis, and PIE with vasculitis, (such as polyarteritis nodosum).

DIAGNOSIS

The physician's primary tool to differentiate the non-asthmatic from asthmatic wheezing patient is a careful history and thorough physical examination. Certainly a chest x-ray should be done in all asthmatics. Pulmonary function studies are helpful, not only in differential diagnosis, but in assessing severity and response to therapy. In certain patients, sweat tests, alpha anti trypsin enzyme studies, immunoglobulin, sinus x-rays, barium swallow x-ray, bronchogram, bronchoscopy, or blood gases would be indicated, depending upon the clinical situation. In those patients who have been found to have bronchial asthma, selected skin tests are often helpful to confirm those specific allergens which are suspected by history of triggering the attacks.

Clinically it is helpful to categorize asthmatic patients into sub-groups. There have been several classifications, but probably the most helpful is the division into "extrinsic" and "intrinsic," (see Table V).¹⁰

Table V
Comparison of Extrinsic and Intrinsic Asthma

	Extrinsic	Intrinsic
Specific allergens	+	0
Nonspecific factors	+	+
Atopic family history	+	0
Associated rhinitis, eczema	+	0
Positive skin tests	+	0
Increased serum IgE	+	0
Eosinophilia	+	+

Those patients with extrinsic asthma are atopic and produce specific IgE antibodies to common environmental antigens. They often have a family history of asthma, and themselves may have other allergic problems such as allergic

rhinitis or atopic dermatitis. Bronchospasm will develop after exposure to allergens, as well as to non-allergic factors. They will have a positive skin test reaction to clinically significant allergens, as well as to some that may not be important. This often is reflected in elevated serum IgE levels, but not often enough to be totally reliable. Eosinophilia is found in both groups and is not a good differentiating point. Symptoms usually begin in childhood and it is unusual to start after age thirty, although there are enough exceptions not to use age alone to classify patients. Children, especially boys, often improve as they grow older (usually in the milder cases), however, other allergic problems often follow. The inherited tendency to wheeze, however, remains, so recurrence can occur under certain circumstances later in life.

Patients with intrinsic asthma have clinically well-defined wheezing. Although none of the recognized external immunologic factors seem to trigger their problems, the non-specific ones mentioned earlier do. There is an absence of atopy in their background and family history. These patients will have negative skin tests and normal serum levels of IgE. Infection, weather changes, pollution, and smoke are among the more common non-specific triggers of asthmatic attacks in these patients, although a specific triggering agent may not be apparent. Intrinsic asthma is found in extremes of age, although this is not invariably so. In some cases infection may be the only triggering factor. This entity has been labeled "infectious asthma" or, in the past, "asthmatic bronchitis." Some children with this problem often will "outgrow" this tendency, while others go on to extrinsic bronchial asthma or allergic rhinitis. In adults, remissions are less common. Many patients who have intrinsic bronchial asthma also have secondary sinusitis. Diagnosis and treatment of the sinusitis, which may not be clinically apparent, can be of great help in controlling their bronchial asthma.

Another sub-group of intrinsic asthma are those patients who have extreme aspirin sensitivity. These patients often have nasal polyps, vasomotor rhinitis, and wheeze when given aspirin or other non-steroidal analgesics, as well as the yellow artificial dye Tartrazine (F.D. and C. #5).¹¹

Following a careful history, physical examination and selected laboratory and skin tests, the physician should be able to classify the individual asthmatic, and tailor the treatment specifically to the patient.

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CASE REPORTS

Raynaud's Phenomenon after Vinblastine-Bleomycin Chemotherapy

HARVEY ROTHBERG, M.D.

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A young man receiving chemotherapy for metastatic testis carcinoma developed Raynaud's phenomenon. Vinblastine is suspected of being the etiologic agent. Raynaud's phenomenon may be a rare side effect of vinblastine chemotherapy.

Teutsch, Lipton, and Harvey¹ reported the case of a 17-year-old youth with stage III testicular carcinoma (mixed embryonal-teratocarcinoma) who developed severe Raynaud's phenomenon after 360 units of bleomycin and 75 mg of vinblastine/m². They speculated that bleomycin was the more likely causative agent, but noted that the two drugs might have acted synergistically.

We recently have observed a similar patient who developed Raynaud's phenomenon after 405 units of bleomycin and 438 mg of vinblastine (221 mg/m²). The sequence of events suggests to us that vinblastine was the major cause of the Raynaud's phenomenon. Possibly vinblastine should be added to the list of causes of Raynaud's phenomenon, which also includes arteriosclerosis obliterans, Buerger's disease, collagen-vascular disease, nerve compression, cryoglobulinemia, and cold agglutinins.

CASE REPORT

A 22-year-old male had a radical right inguinal orchiectomy in October, 1973 for teratocarcinoma of the right testis. Lymphangiography and inferior venacavagram showed suspicious nodes in the right para-aortic area. In November, 1973 he had 2100 rad ⁶⁰Co teletherapy to the para-aortic area and iliac areas preoperatively. In December, 1973 bilateral retroperitoneal lymphadenectomy was done; the specimen contained six nodes involved with mixed teratoma-embryonal cell carcinoma with a few chorio-

carcinoma elements. Chest x-ray postoperatively showed a two cm left pulmonary nodule. Triple chemotherapy with chlorambucil, methotrexate and dactinomycin² was given from January to March, 1974; this therapy was accompanied by nausea on multiple occasions, stomatitis once, and leukopenia to 3200/mm³. However, the left pulmonary mass continued to enlarge to four cm in diameter. In May, 1974 the patient had 4600 rad ⁶⁰Co teletherapy to a 7 x 6 cm port in the left upper lobe, with 80 percent decrease in the size of the mass. In November, 1974 the patient had a thoracotomy and left upper lobectomy. Only necrotizing granuloma and pulmonary fibrosis and vascular sclerosis, but no tumor cells, were noted within the pulmonary tissue; however, there were several metastatic nodes containing teratoma in the hilum and mediastinum.

It was decided to begin bleomycin-vinblastine chemotherapy.³ At that time it was felt that bleomycin dose was limited by pulmonary toxicity, but vinblastine might be maintained indefinitely with dose to be modified chiefly on the basis of myelotoxicity or neurotoxicity. A total of 405 units of bleomycin (205 mg/m²) was given intramuscularly from December, 1974 to March, 1975. A total of 438 mg of vinblastine (221 mg/m²) was given intravenously from

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December, 1974 to February, 1977. Bleomycin therapy was followed by slight nausea and occasionally by vomiting. Partial alopecia began in December, 1974 and continued through March, 1975. A mild pruritic and maculonodular dermatitis over knuckles and fingertips and redness and burning over elbows was present in January through March, 1975. In March, 1975, slight dullness at left base was noted (no râles), but chest x-ray showed only unchanged post-operative pleurodiaphragmatic adhesions on the left. The final 15 mg of bleomycin (for total 405 mg) was given on March 31, 1975.

In May, 1975 the patient had left pleuritic pain; on June 30th physical examination and chest x-ray suggested a small pleural effusion. On July 1st thoracentesis yielded 30 cc of bloody fluid, negative for malignant cells. In September, the patient was married. Vinblastine therapy was continued with occasional nausea or diarrhea after the injections, generally eight to ten mg intravenously every two weeks. Headache and body aches occurred after each of three injections of 15 mg vinblastine, but not after lesser doses. On one occasion in June, 1975, a local extravasation led to a two cm area of redness, pain and tenderness on the dorsum of left hand which lasted for about a month. White blood cell count generally was diminished; however no paresthesias were noted.

Alopecia recurred in October and November, 1976. In December, 1976 the patient noted that his fingers began to turn white and to feel uncomfortably cold in cold weather. Vinblastine therapy was terminated on February 8, 1977 after a final seven mg. dose (for total 438mg). In March, 1977 the patient was somewhat depressed and complained of constantly cold hands which became painful and achy in very cold weather. He improved over the summer, but by October, 1977 the Raynaud's phenomenon again appeared. The hands felt cold at all times, but were worse in cold weather. They were white and numb (but not painful) in the distal four cm of each digit.

At this time, physical examination revealed a healthy appearing young man, with cold fingers, and hypoactive reflexes (absent in arms, 1+ knee jerks). There was no evidence of tumor. Chest x-ray was negative except for pleural scars at the left base. Complete blood count and blood chemistry (including LDH and alkaline phosphatase) were normal. The β -subunit of HCG was less than 1 mIU/ml, as it had been since first measured in July, 1976. Antinuclear antibody test and cryoglobulins were negative. The patient is a nonsmoker. Tolazoline (Priscoline®) therapy was ineffective, but guanethidine (Ismelin®) has given some relief of the symptoms.

DISCUSSION

The management of this patient's metastatic testicular cancer was begun before the general use of the cis-platinum combination chemotherapy regimens which are now considered to be the most effective therapy.^{4,5} The treatment in this case involved sequential radiotherapy, surgery, and chemotherapy. The presence of mediastinal metastases at the time of the thoracotomy seemed to call for a change from chlorambucil-methotrexate-dactinomycin to an alternative regimen, and in 1974 the use of bleomycin and vinblastine in

combination seemed most appropriate.³ The development of pleural reaction in June 1975 (two months after bleomycin was discontinued) suggested the possibility of smoldering neoplasia in the chest, and vinblastine therapy was maintained for another 20 months, until the advent of symptomatic Raynaud's phenomenon. This was 22 months after bleomycin had been discontinued.

This patient, apparently now free of neoplastic disease, has experienced a variety of toxic effects of cancer chemotherapy. The chlorambucil-methotrexate-dactinomycin regimen was associated with stomatitis, nausea, and leukopenia. Bleomycin therapy was associated with dermatitis and alopecia. However, the most striking toxic manifestations in his case appear to be related to vinblastine therapy which was continued over a period of 26 months. These include occasional nausea and diarrhea; headache and body aches after 15 mg. doses; local tissue damage after extravasation; leukopenia; alopecia; neurotoxicity manifest by diminished deep tendon reflexes; Raynaud's phenomenon which has persisted for at least 10 months after discontinuing vinblastine; and possibly mental depression.

In contrast to the case reported by Teutsch, Lipton and Harvey¹ in which Raynaud's phenomenon developed while the patient was receiving both bleomycin and vinblastine, in our patient the sequence of events strongly suggests that vinblastine was the major causative agent. While the pathogenesis of the Raynaud's phenomenon remains a matter of speculation, it is perhaps consistent with the known neurotoxicity of the drug. This neurotoxicity has been recognized principally as paresthesias and hyporeflexia due to peripheral neuropathy, but there may also be central effects as suggested by the less common findings of headache and depression.

Such an experience again calls attention to the fact that potent chemotherapy is a two-edged sword, for which the possible benefits always must be balanced against the potential hazards and toxic effects. In the case of disseminated testicular cancer, as data accumulate on late recurrences, it may be possible to define time limits for optimal continuation of maintenance chemotherapy after the achievement of complete remission, so as to minimize unnecessary toxicity.

It would be of interest to know if others have observed Raynaud's phenomenon as a sequela of vinblastine or combination chemotherapy in patients with neoplastic disease.

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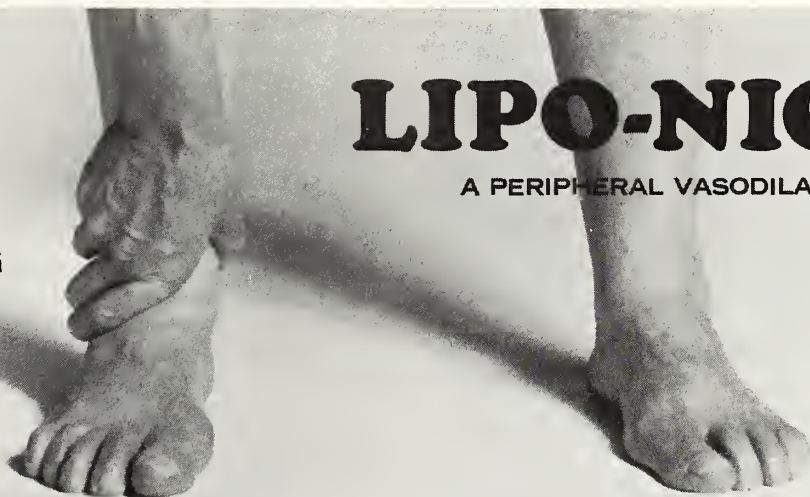
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Atrial Dissociation*

SHASHI K. AGARWAL, M.D., and
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A patient with a rare atrial dysrhythmia, atrial dissociation, is described. A possible relationship to chronic obstructive pulmonary disease is considered.

Atrial dissociation is a rare electrocardiographic occurrence. When observed clinically, it usually occurs in preterminal patients with intractable heart failure and is associated with a poor prognosis. It is characterized by the presence of a unilateral ectopic atrial rhythm independent of the basic rhythm.¹⁻⁴ The basic rhythm conducting impulses to the ventricles is usually sinus rhythm,^{1,2,5} but ectopic atrial tachycardia³ or A-V nodal rhythm also may be seen.^{6,7} The unilateral ectopic rhythm is commonly a slow rhythm, but occasionally it may be tachycardia,¹ flutter,² or fibrillation.⁸ The basic rhythm and the unilateral atrial rhythm never interfere with each other and the independent atrial rhythm is never conducted to the ventricles.^{2,7} Although the existence of atrial dissociation has been doubted by many investigators, it now is accepted generally as a unique electrocardiographic entity.

We recently saw a case of atrial dissociation in which the ventricles were controlled by the left atrium while independent right atrial activity was noted at a slower rate. The purpose of this communication is to call attention to this rare phenomenon which easily may be interpreted as artifactual.

CASE REPORT

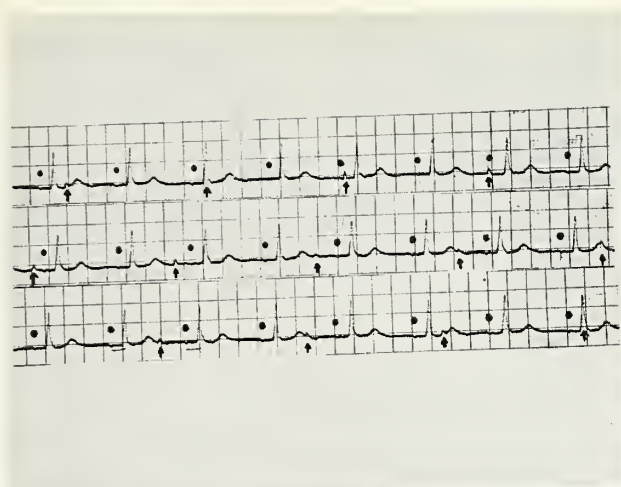
A 66-year-old female with a longstanding history of habitual excessive smoking and chronic obstructive pulmonary disease was admitted to the hospital with congestive

heart failure. On admission an electrocardiogram revealed normal sinus rhythm at a rate of 63 per minute with upright P waves in all leads except AVR. On the second hospital day, the failure was more severe and an electrocardiogram now showed a left atrial rhythm at a rate of 76 per minute conducting regularly to the ventricles. In addition, independent P waves were noted at a rate of 40 per minute. None of these conducted to the ventricles irrespective of their time of occurrence in the cardiac cycle. Further, the nonconducting P waves were upright in all leads except AVR, and their configuration was different from that of the sinus P waves noted the day earlier. Careful examination of the patient failed to disclose any source for possible artifacts. On the third hospital day there was considerable improvement in the patient's condition and an electrocardiogram revealed reversal to the sinus rhythm recorded on admission. Repeated tracings during the remaining period of the patient's hospitalization failed to demonstrate any further atrial arrhythmias.

DISCUSSION

Atrial dissociation was observed as early as 1900 by Hering in the mammalian heart preparation.⁹ In 1906, Wenkebach observed this phenomenon in a patient.¹⁰ Subsequent

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Figure—Continuous rhythm strip of Lead II on the 2nd day of hospitalization showing a left atrial rhythm at a rate of 76 per minute (dots) while independent nonconducting upright P waves (arrows) are seen occurring regularly at a rate of 40 per minute.

publications, although describing examples of this arrhythmia continued to be skeptical about its authenticity.¹¹⁻¹³ In 1964 Scherf reviewed all published reports and unequivocally showed the existence of atrial dissociation.⁷ Numerous reports subsequently have provided further evidence for the validity of this rare arrhythmia.^{1,8,14}

FEATURES AND DIFFERENTIAL DIAGNOSIS

The characteristic feature of atrial dissociation is the presence of two independent atrial complexes with only one of these controlling the ventricles.¹⁻⁵ The nonconducting ectopic rhythm is usually a slow rhythm, between 30 to 50 beats per minute, and is localized to a portion or all of one atrium.² Due to the small area depolarized, the nonconducting P wave is usually smaller than the conducting P wave. Occasionally the ectopic P wave may be superimposed on the P wave of the basic rhythm resulting in large and bizarre P waves. These are pseudo-fusion beats because the two atrial impulses do not meet in the atrial tissue due to the existence of a bidirectional block, which insulates them from each other.^{15,16}

Atrial dissociation has to be differentiated from other conditions presenting with two sets of P waves. In atrial parasystole, the ectopic P waves are usually similar to or even larger than the sinus P waves, the interectopic interval is less variable than in atrial dissociation, and the absence of a bidirectional block is exemplified by the ectopic P waves conducting to the ventricles, whenever the myocardium and the conduction system are nonrefractory.¹⁷⁻¹⁸ Blocked atrial premature beats occurring regularly may be differentiated by their constant coupling intervals.¹⁹ Artifacts may closely simulate ectopic P waves,²⁰⁻²¹ and usually can be ruled out by close examination of the patient to detect any loose electrodes or hiccoughs, although occasionally this may be impossible. A history of cardiac transplantation will be evident in heart recipients whose electrocardiograms are identical to those of patients with atrial dissociation; the recipient's own cardiac tissue produces a unilateral ectopic rhythm while the donor's heart controls the dominant rhythm.²²

ETIOLOGY

Atrial dissociation invariably is found in patients with intractable congestive cardiac failure, usually a few hours before death. Its presence in critically ill patients thus

prognosticates impending death, although its association with benign conditions also has been noted.⁴ In our patient the clinical recovery coincided with the disappearance of this atrial arrhythmia.

It is possible that the presence of chronic obstructive pulmonary disease (COPD) in our patient was an important initiating or contributing factor in the development of atrial dissociation. Corazza and Pastor first drew attention to arrhythmias in chronic obstructive pulmonary disease.²³ Other authors have reported the incidence of arrhythmias in hospitalized patients with COPD varying from rare to as high as 47 percent.²⁴⁻²⁶ Atrial arrhythmias are more common than ventricular arrhythmias,^{27,28} with multifocal atrial tachycardia being the most common atrial arrhythmia seen.²⁹ Although less common, ventricular arrhythmias have a much more grave prognosis.^{24,26} Any arrhythmia, however, may aggravate the already existing tissue hypoxia by causing a reduction in the cardiac output.²⁸ Various mechanisms are postulated to be responsible for the arrhythmias seen in COPD, including hypoxia, acidosis, digitalis bronchodilator therapy, and electrolyte imbalance.³⁰ No definite relationship between COPD and atrial dissociation has, however, been reported so far.

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Rupture of the Gallbladder Secondary to Blunt Abdominal Trauma

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A case of ruptured gallbladder and a patient with avulsion of the gallbladder secondary to blunt abdominal trauma are reported. Pathogenetic factors and diagnosis are discussed. Treatment may be altered to fit the clinical situation and degree of anatomical disruption, but the procedure of choice remains cholecystectomy.

Rupture of the gallbladder secondary to blunt abdominal trauma (BRGB), especially when occurring as an isolated injury, is an unusual event. Prior to 1969, there were 51 cases documented in the English literature. Since then, 17 more reports have appeared in the world literature.

CASE REPORTS

Case #1—A 28-year-old male sustained blunt right upper quadrant trauma from a steering wheel in auto accident after a drinking bout. The patient rapidly developed signs and symptoms of moderately severe hypovolemia. Physical examination revealed an abrasion in the right upper quadrant and a rigid, distended abdomen. X-rays of the abdomen showed elevation of the right hemidiaphragm. At laparotomy two hours after the accident, 1,000 ml. of bloody fluid were removed from the abdominal cavity. An actively pumping artery in the free edge of a three cm. laceration in the fundus was controlled by cholecystectomy. Microscopic sections through the thin-walled gallbladder showed marked serosal hemorrhage and no inflammation. The postoperative course was uneventful.

Case #2—A 48-year-old male sustained blunt chest and abdominal trauma and a fractured right ankle in an auto accident. Physical examination revealed a contusion in the right upper quadrant. The abdomen became distended and the patient developed signs and symptoms of hypovolemia. Laparotomy was performed within three hours after the

accident; the abdominal cavity contained 1,000 ml. of fresh blood and clot. An avulsion of the distal one-half of the gallbladder was noted. The gallbladder was removed and liver bed repaired. The thin-walled specimen contained extensive hemorrhage with focal areas of mucosal necrosis. The postoperative course was essentially uneventful.

DISCUSSION

The earliest recorded case of BRGB dates back to 1388 and is preserved in Guys Museum (Specimen 1388).¹⁸ It involved a 29-year-old man who was kicked in the abdomen and died on the 178th day from peritonitis. In a collective review of 27 traumatically ruptured gallbladders in 1905, Ricketts¹⁸ found four survivors. This was attributed to spontaneous development of a fistula. In 1890, Courvoisier⁶ advocated active treatment of BRGB by means of repeated paracentesis. In 1898, Bullinger⁵ performed a cholecystorraphy with survival. Also, in 1898, Ricketts performed the first successful cholecystectomy.

In a collected series of 5670 cases of penetrating and non-penetrating abdominal trauma, there was a 1.9 percent incidence of gallbladder injury.¹⁵ Between eight and ten percent were caused by blunt trauma.^{18,19} Fifty percent of the

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blunt trauma cases involved at least one additional organ.⁸ Males predominated in all groups.

PATHOGENESIS OF GALLBLADDER RUPTURE

Currently, steering wheel accidents are the most common cause of BRGB. The relative fixation of the gallbladder to the liver makes it susceptible to *avulsion* by a shearing action from an external force. Factors predisposing to *rupture* of the gallbladder are (a) thin wall, (b) interdigestive phase with gallbladder distended, (c) alcohol prior to injury. Alcohol can cause increased tone in the sphincteric mechanism at the choledochoduodenal junction.¹⁶ When the hydraulic pressure generated from a blow exceeds the rate of dissipation of bile by ductal egress, the fundus of the gallbladder usually ruptures. This results in a discharge of bile and blood into the peritoneal cavity.

The bile may become loculated or spread diffusely, resulting in choleperitoneum. Hypertonic bile excites a peritoneal effusion causing bile ascites with loss of fluid from the circulating blood volume. If the bile becomes infected, a profound peritonitis ensues. The rate of hemorrhage is reflected in the signs and symptoms of hypovolemia. Should clotted blood block the cystic duct, *traumatic* cholecystitis—a rare occurrence—may develop. Of the seventeen cases reported in the literature since 1969, fifteen were ruptured, one contused, and one avulsed.

CLINICAL APPEARANCE

Symptomatically, *contusion* of a gallbladder will cause vague right upper quadrant and hypochondrial discomfort, muscle spasm and mild digestive complaints. It may lead to necrosis and late perforation. *Avulsion* of a gallbladder sets off fulminating signs and symptoms of hemoperitoneum. Also, volvulus of the detached organ may occur, resulting in gangrene. *Ruptured* gallbladder is difficult to diagnose specifically preoperatively. Rarely is the lesion suspected unless paracentesis produces bile-stained fluid.

Signs and symptoms of abdominal distention, peritoneal irritation, and hypovolemia are variable in onset, severity, and duration. Hemoconcentration, leukocytosis, biliruria, hyperbilirubinemia, and acholic stools are inconstant findings. Bile may appear in the urine by the third day after injury, and jaundice may become evident by the fourth day.¹ A rise in serum alkaline phosphatase may appear later.¹⁴ *Traumatic* cholecystitis simulates the usual signs and symptoms of cholecystitis.

Abdominal roentgenograms may suggest the presence of free fluid, intestinal displacement away from the right upper quadrant, or a paralytic ileus.

SURGICAL TREATMENT AND RESULTS

The treatment of a ruptured gallbladder can be summarized:

(1) Paracenteses, as advocated by Courvoisier in the nineteenth century, are obsolete except for diagnostic purposes.

(2) Cholecystorrhaphy is an insecure procedure.

(3) Tube cholecystostomy may be the preferable procedure in infants and children.²¹

(4) Cholecystectomy is the procedure of choice in an adult.

In reviewing the seventeen most recently reported cases of BRGB from the literature, thirteen were treated with

cholecystectomy, two with cholecystostomy, one with cholecystorrhaphy and cholecystostomy, and one with cholecystorrhaphy. There was one death in a case with multiple organ involvement treated with cholecystorrhaphy.²⁰

In a collective review of 39 cases of BRGB from the Russian literature in 1973, 27 had cholecystectomies, eight cholecystorrhaphies, one fixation in bed. The procedure was unknown in three cases. The postoperative mortality was 5.2 percent¹⁷ in this series; however, in another Russian series where other abdominal organs were involved, six of seven patients died.¹²

SUMMARY

(1) The incidence, pathological physiology, classification, and surgical treatment of BRGB are reviewed.

(2) A case of rupture and a case of avulsion of the gallbladder secondary to blunt abdominal trauma are reported.

(3) The prognosis of BRGB is good if the diagnosis is made early and there are no serious associated injuries. Awareness of the signs and symptoms and a high index of suspicion would shorten the interval between injury and treatment. Although treatment may be altered to fit the clinical situation and degree of anatomical disruption, the procedure of choice remains cholecystectomy.

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Adverse Reaction to Intravenously Injected Marihuana*

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This case report outlines the clinical, biochemical, and hematological findings of two patients hospitalized because of after-effects of intravenous injection of crude marihuana. Symptomatic care for a week brought marked improvement in the clinical condition and in laboratory test results of both patients suggesting that all marihuana-induced immediate effects seen were reversible.

Marihuana is either inhaled by smoking, orally ingested, or intravenously injected by its users. Whereas a large number of reports in the literature describe the psychological and pathophysiological effects associated with marihuana smoking, little attention has been focused on the effects of marihuana administered intravenously or ingested orally.¹ An account of the clinical and laboratory findings, particularly the hematologic manifestations, of two patients brought to the hospital in acute distress from the after-effects of intravenous injection of marihuana, is presented in this report.

CASE REPORTS

The patients, one aged 20 (Case 1) and the other 21 (Case 2), were friends and had injected themselves intravenously with an undetermined quantity of crude marihuana broth several hours prior to being brought to the hospital. Chief presenting symptoms common to both cases were shaking chills, nausea, vomiting, frequent and copious diarrhea, generalized myalgia, and abdominal cramps.

Case 1 had taken amphetamines and smoked marihuana on a few occasions in the past. At admission he was alert, cyanotic, and dehydrated. The blood pressure was 74/50 mm Hg, the pulse 130, the respirations 26, and the temperature 37.4°C. Physical examination revealed a diffusely tender abdomen with active bowel sounds; the liver was palpable one cm below the right costal margin.

Case 2, who had a history of drug use (mainly marihuana smoking) for the past nine years with a previous exposure to hepatitis, complained also of dyspnea, tachypnea, and severe headache. At admission the blood pressure was 82/64 mm Hg, the pulse 102, the respirations 22, and the temperature 37.4°C. Results of arterial blood gas analyses (pH 7.40, pO₂ 40, pCO₂ 23.5, CO₂ content 15.5, %O₂ sat. 75) were suggestive of hyperventilation. Abdominal tenderness localized to both hypochondrial regions was noted.

Pertinent laboratory findings at admission (A) and following 3 to 6 days of symptomatic management (B) are given below:

	Biochemical Findings				
	Case 1		Case 2		Normals
	A	B	A	B	
BUN (mg/dl)	53	20	46	17	10-20
Creatinine (mg/dl)	3.4	0.9	2.9	1.0	0.8-1.5
Inorganic phos (mg/dl)	6.2	4.2	5.5	3.8	2.5-4.5
Uric acid (mg/dl)	9.8	5.1	10.0	5.8	3.1-8.0
C.P.K. (m I.U./ml)	398	16	17	15	10-70
Total bilirubin (mg/dl)	1.3	0.8	1.8	1.0	0.2-1.2
L.D.H. (mU/ml)	255	155	280	135	85-200
S.G.O.T. (mU/ml)	143	105	183	45	5-40
S.G.P.T. (I.U./l)	52	75	105	—	4-25

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Cholesterol (mg/dl)	75	115	155	158	150-280
Calcium (mg/dl)	6.7	9.5	8.5	8.7	8.5-10.7
Total protein (g/dl)	5.3	7.0	6.0	6.2	6-8
Sodium (meq/l)	133	152	140	139	133-145
Potassium (meq/l)	4.0	4.2	5.5	4.1	3.8-5.2
Chloride (meq/l)	100	110	102	103	99-108

Hematologic Findings					
	Case 1		Case 2		
	A	B	A	B	
Hemoglobin (g/dl)	17.7	15.3	18.4	15.7	
WBC (x 10 ⁹ /l)	27.9	7.5	35.0	9.4	
Differential (%)					
poly	50	44	63	59	
band	45	0	25	1	
lymph	3	36	1	31	
mono	2	13	6	7	
eos	0	7	0	2	
meta	0	0	5	0	
Toxic granules & vacuoles ^a	2+	none	4+	none	
Platelets (x 10 ⁹ /l)	59	189	86	112	
Coagulation profile ^b	Normal		Normal		

	Urinalysis ^c	
	Case 1	Case 2
Protein	Trace	Trace
Microscopic	Few epithelial cells, WBC and granular casts	Many epithelial cells, few hyaline and granular casts

	Electrocardiogram ^b	
	Case 1	Case 2
	Sinus tachycardia with slight ST segment elevation in V ₁ , V ₂ , V ₅ and V ₆	Suggestive of cor pulmonale

	Lung scan ^b	
	Case 1	Case 2
	Suggestive of "smoker's lung"	Suggestive of "smoker's lung" with possible microemboli

^a See Figure 1
^b Findings at admission only
^c Urinalysis performed 3-6 days after admission revealed normal results

COMMENTS

Symptoms, physical findings, and laboratory test results pertaining to gastrointestinal, hepatic, and renal system impairment presented by our patients closely conform to previously reported²⁻⁴ observations on the toxic effects of the intravenous injection of crude marihuana. Hematologic changes under similar conditions have been reported to

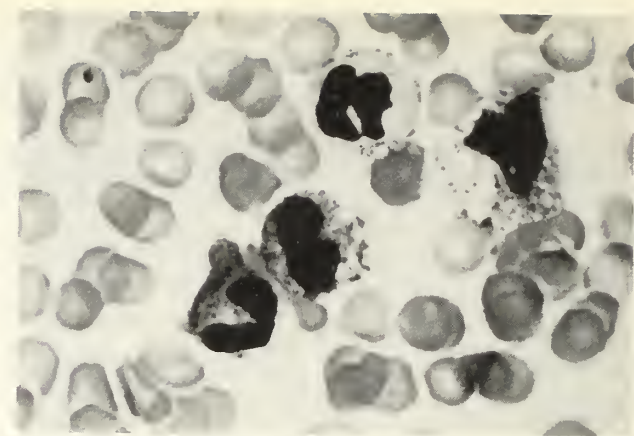


Figure 1—Peripheral blood smear showing leukocytosis with shift to the left and marked toxic granulation and vacuolization (case 2, Wright stain, X 500).

include initial transient leukocytopenia^{3,5,6} followed by leukocytosis with shift to the left,³⁻⁵ thrombocytopenia,^{2,3,5} and anemia.^{2,3} Leukocytosis with shift to the left and thrombocytopenia were noted in both of our patients. Initial transient leukocytopenia may have been missed in our cases because of the interval of several hours between the injection of marihuana and the time when medical care was sought. A transient increase in hemoglobin level observed in both of our patients was, we believe, due to hemoconcentration resulting from fluid loss. Toxic granulation and vacuolization, an added hematologic feature noted in both cases, presumably represents a reaction to the injection of a crude substance of foreign nature. Significant improvement in clinical condition and laboratory findings ensued following one week of symptomatic care in both cases. Mechanisms underlying the reported toxic effects of intravenously administered marihuana are understood only partially and require further studies.²

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Update: Treatment of Rheumatic Disease

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In treating a patient with rheumatic complaints, the physician first should attempt to make a specific diagnosis. As treatment progresses adequate means of assessing the efficacy or side effects of the drug are needed. Rheumatoid arthritis and the spondyloarthropathies often require strong anti-inflammatory medication, while patients with osteoarthritis need less powerful treatments. Gouty attacks can be prevented by once again making the specific diagnosis and instituting appropriate drugs.

The foundation of treatment of the rheumatic diseases requires an appropriate diagnosis. The clinical evaluation, including historical data, general examination, and a careful musculoskeletal examination, help to form a differential diagnosis. This then can be evaluated more adequately, if needed, with such sophisticated testing as bone scanning, ANA, HLA-B27 antigen, and so on. Once the diagnosis is made, therapy can be instituted.

THERAPEUTIC AIMS

In most of the rheumatic diseases the goals of therapy are not directed toward cure, but rather (1) relief of pain, (2) improvement of function, (3) prevention of progressive deformities. Although this paper deals only with the medical aspects of antirheumatic therapy, I would like to emphasize that a comprehensive approach, including proper physical and emotional rest, exercise program, nutrition, appropriate splinting, and often surgical procedures are needed in the "basic program."¹

EVALUATION OF ANTIRHEUMATIC THERAPY

A problem encountered in the use of various forms of anti-inflammatory therapy is the ability to evaluate the patient's response. Subjective response is certainly not enough. For example, a patient placed on moderate-dose corticosteroid therapy will "feel great," although objective criteria may show progression of the disease process. For this reason,

parameters of inflammation should be evaluated. These include the duration of morning stiffness, onset of afternoon fatigue, signs of objective inflammation and laboratory tests such as the Westergren sedimentation rate. Utilizing these parameters the physician can obtain a useful guide as to whether the patient is improving.

PROGRAM IN SPECIFIC RHEUMATIC DISEASES

(a) **Rheumatoid arthritis.** (Rheumatoid arthritis will be used here as a prototype of the inflammatory rheumatic diseases).

1. *Salicylates* have been utilized in the treatment of arthritis for almost two hundred years. Acetylsalicylic (ASA) has been the most useful salicylate. Although the beneficial effects of aspirin have been known for a long time, the exact mode of action is still speculative. There have been some data to indicate that salicylates may stabilize lysosomes.² Dosage is most important since anti-inflammatory salicylate levels must be obtained. This often will require three to four grams per day in the adult patient. In children, salicylates are given in doses of up to 50mg. per pound, in an attempt to obtain a salicylate level of between 20 and 30mg/dl. Gastric irritation can be avoided by having the patient take the aspirin with meals and at bedtime with a snack. The clinical adage

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"push to tinnitus, then back off slightly" is valuable in regulating the aspirin dosage; however, in elderly patients tinnitus is not that reliable a guide, so that serum salicylate levels occasionally are required.³ Poor patient compliance seems directly related to physician indifference to aspirin. A physician may be able to overcome poor patient compliance by careful education and explanation into the benefits and lack of side effects with aspirin therapy. Other problems, such as a true allergic reaction or hypoprothrombinemia in the presence of hepatic disease or with concomitant administration of anticoagulants, are rare. In attempting to reduce gastrointestinal irritation, several other forms of salicylates have been promoted. An example is choline magnesium trisalicylate (Trilotate®), which has been shown to be as effective as acetylsalicylic in rheumatoid arthritis, while having less gastrointestinal side effects.⁴

2. *Newer nonsteroidal anti-inflammatory agents (NSAIA).* In the last few years, several drugs have been promoted as being as effective as aspirin therapy with less side effects: ibuprofen (Motrin®), fenoprofen calcium (Nalfon®) and naproxen (Naprosyn®) are propionic acid derivatives which share the above properties. The disadvantages are much higher costs and unknown side effects. In double-blind clinical tests these drugs were shown to be "as effective as ASA." The nature of double-blind studies, however, generally does not allow aspirin to be individualized (push to tinnitus), so that maximum ASA effectiveness is not truly measured. Tolmetin (Tolectin®) is supposedly a pyrrole, closely related to indomethacin, but without accompanying side effects.

3. *Gold salts* have been utilized in the treatment of rheumatoid arthritis for approximately forty years. There have been double-blind studies corroborating its clinical usefulness. A recent paper actually demonstrates the slowing down of radiologic abnormalities, as well as showing clinical improvement.⁵ Therapy with gold salts can be cumbersome and difficult: weekly injections must be given; the results of therapy can take several months; side effects such as pruritic skin rash and proteinuria are very common and can occur in up to 20 percent of patients. More serious side effects such as thrombocytopenia, severe renal involvement or aplastic anemia do occur, but much less frequently. These usually can be avoided with frequent blood counts and urinalyses. Gold never has been shown to be helpful in osteoarthritis, gout, or any other type of rheumatism; it should be reserved strictly for patients with rheumatoid arthritis. It may be helpful in the arthritis of both psoriasis and systemic lupus erythematosus when the clinical picture overlaps with rheumatoid arthritis. Minor side effects, such as mild skin rash or proteinuria, can be overcome either by diminishing the dose of gold given or increasing the length of time between injections. Often therapy is stopped prematurely because of a mild skin rash or mild proteinuria or other minor reaction. The earlier gold therapy is initiated in the rheumatoid process, the better the opportunity for obtaining good results.

4. *D-Penicillamine* is so named because it is a degradation product of penicillin and is prepared by hydrolyzing penicillin. It long has been known to be an effective chelator of various metals. It is extremely effective in the treatment of Wilson's disease. Jaffe⁶ is the leading proponent of its use for rheumatoid arthritis in the United States. Although it does not yet have FDA approval for use in rheumatoid arthritis in this country, its effectiveness in treating this disease has been shown throughout the world. Most rheumatologists pre-

scribe it despite the fact that its mode of action in rheumatoid arthritis is unknown. At present, therapy is instituted with a 250mg. capsule per day for approximately one month. If the patient has no side effects, one capsule is added each month. Usually two to four capsules a day are needed to help control the inflammatory process. Side effects, including acute hypersensitivity reactions and hypogeusia can occur. Serious complications, such as thrombocytopenia and nephrotic syndrome have been reported, therefore, frequent blood counts and urinalyses must be obtained.

5. *Chloroquine* and various immunosuppressive agents, such as azathioprine (Immunar®), are beyond the scope of this paper and will not be discussed here.

(b) **Osteoarthritis**—Osteoarthritis, or degenerative joint disease, is associated with considerably less inflammation than rheumatoid arthritis. For this reason, less potent anti-inflammatory therapy is needed, but measures to avoid stress on the particular areas of involvement are required. Analgesics such as aspirin, phenacetin, or propoxyphene often suffice, along with appropriate physical therapy. Occasionally there is accompanying inflammation, as with osteoarthritis of the hip. Anti-inflammatory therapy utilizing high doses of salicylates or one of the new nonsteroidal anti-inflammatory agents may be tried. At present, Motrin® and Nalfon® have FDA approval for osteoarthritis. Indomethacin also has been shown to be extremely helpful in cases of osteoarthritis of the hip.

(c) **Spondyloarthropathy**—In recent years, the definite association between antigens of the major histocompatibility system (HL-A) and specific rheumatic diseases has been reported. In particular, the genetic marker B-27 now is known to be present in a great majority of patients with ankylosing spondylitis⁷ or Reiter's disease and, less frequently, in individuals with inflammatory bowel disease and psoriasis. These diseases, since they share a common genetic marker and some shared clinical findings, recently have been grouped under the heading of spondyloarthropathy. One of the common characteristics is the overall poor response to salicylates as compared to rheumatoid arthritis. The spondyloarthropathies, particularly when there is a moderate degree of axial skeletal involvement, seem to respond best to indomethacin or phenylbutazone. Relief often can be dramatic in these diseases with the use of these medications. In fact, it has been said that the clinical diagnosis of ankylosing spondylitis can be secured with a therapeutic trial of indomethacin, since most patients will have such dramatic relief. The average dose of indomethacin required for patients with spondyloarthropathy is approximately 75 to 100mg. Two major side effects are gastrointestinal and neurological in nature. In one study⁸ with long-term therapeutic trials of 234 patients, central nervous system side effects in 20 percent of patients and gastrointestinal symptoms in 12.5 percent were severe enough to warrant cessation of the drug. Educating a patient about the side effects can decrease high incidence of problems. Patients are instructed to take the indomethacin with milk or food (never on an empty stomach), and never to take it with salicylates or other ulcerogenic agents such as alcohol. Side effects are much more frequent in the geriatric population. However, since most patients with spondyloarthropathies are younger, this presents few problems. Phenylbutazone is also an effective drug in spondyloarthropathies,⁹ but initial careful screening for blood dyscrasia and frequent blood counts are recommended. If patients can tolerate this drug several weeks they usually have no difficulty in the long run. The dose required in these

diseases is between 200 and 400mg. per day.¹⁰ Other than blood dyscrasia, the major side effects are gastrointestinal problems and fluid retention. Once again, this drug is not to be used with salicylates or other ulcerogenic drugs, and always should be taken with milk or food.

(d) **Vasculitis**—The diseases included here are a diverse group of entities with varying clinical features: polyarteritis nodosa,¹¹ systemic lupus erythematosus, temporal arteritis, polymyalgia rheumatica and Takayusa's disease, to name but a few. It is often difficult to label the exact type of vasculitis present. For this reason, it is more important to determine the size of the vessel involved and the clinical sequela when determining the therapeutic program.¹² For example, a patient with temporal arteritis with the sequela of possible blindness needs immediate massive corticosteroid therapy. This would be in contrast to a patient with mild systemic lupus erythematosus presenting with a mild polysynovitis, who may only require low-dose steroids; even possibly only aspirin therapy. The common feature of these diseases is the pathogenetic mechanism of inflammation of blood vessels, probably by immune complex deposition and complement activation. Because of the limitation of space, only two specific entities will be discussed in the subsequent paragraphs.

1. *Systemic lupus erythematosus*. This is a type of vasculitis which is protean in its clinical manifestations. A physician may be presented with a patient who has only mild arthralgia, while another may be dying of severe manifestations involving multiple organs including the kidneys, lungs, or heart. In this disease particularly, one must correlate the degree of involvement with the therapeutic program. In patients with only mild synovitis or malaise, anti-inflammatory therapy with high-dose salicylates or the non-steroidal anti-inflammatory drugs may be all that is required. However, with more serious manifestations, including hematologic abnormalities such as thrombocytopenia, severe pleurisy, or pericarditis, moderate-dose corticosteroid therapy (20 to 40mg. prednisone per day) may be required. In patients with diffuse necrotizing glomerulonephritis, massive doses (60 to 100mg. per day) may be required for long periods of time. Each case must be individualized. The clinical picture, along with the Westergren sedimentation rate, and, in more serious cases, serum complement and anti-DNA levels are useful guides to therapy. The potential side effects of corticosteroids are well known; for this reason, the smallest dose necessary to control the clinical manifestations should be used. Antimalarial drugs, such as chloroquine, have been mentioned as useful agents in the treatment of systemic lupus erythematosus and have been suggested as corticosteroid-sparing agents.¹³ However, their use is limited, because serious permanent retinopathy can occur.¹⁴ In mild cases, the corticosteroid agents never should be the initial anti-inflammatory mode of treatment; they should be used only after other forms of therapy have proved ineffective. Relative contraindications to their use, such as active peptic ulcer disease, active tuberculosis and diabetes mellitus, should be excluded. The physician should become familiar with one type of corticosteroid agent, e.g., prednisone, rather than attempting to learn the many different agents available at present. Corticosteroid agents rarely should be used "just to make the patient feel better." For this reason, corticosteroid agents were not mentioned in the discussion of the treatment of rheumatoid arthritis, which is a non-fatal chronic disease. Steroid withdrawal can be a very difficult problem, and symptoms such as fatigue, weakness, arthralgia

and myalgia (so-called pseudorheumatism) often can be difficult to differentiate from the underlying disease one is treating.¹⁵

2. *Polymyalgia rheumatica*. Although histologic evidence of vasculitis has not been shown in this disease process, its frequent association with temporal arteritis (as much as one-third) often finds this entity listed with the discussion of vasculitis.¹⁶ This disease should be considered in any patients above the age of sixty complaining of diffuse musculoskeletal pain, particularly if their Westergren sedimentation rate is 60mm. or above. If other entities can be excluded, such as occult carcinoma or other collagen diseases, the above-mentioned features are enough to substantiate a diagnosis. A short course of one to two weeks of prednisone, 20 mg. per day, often will produce a dramatic response, with both the patient and the Westergren sedimentation rate improving remarkably. Subsequently, a small dose, e.g., 5 to 7-1/2mg. of prednisone, is often enough to keep the patient completely asymptomatic. This disease process can last from several months to quite a few years, so that once again therapy has to be tapered to suit the individual case. Clinical manifestations and Westergren sedimentation rate again must be followed. Before starting therapy, evidence of temporal arteritis should be sought, i.e., temporal pallor on fundoscopic examination, temporal artery tenderness, or nodularity. If these are present, a temporal artery biopsy should be performed. The additional diagnosis of temporal arteritis warrants much higher doses of corticosteroid therapy for a more prolonged period of time.

(e.) **Metabolic arthropathy—**

1. *Gout* is a metabolic arthropathy induced by the deposition of sodium urate crystals within a joint space.¹⁷ An acute inflammatory synovitis is initiated, causing rather severe pain and disability. The treatment of this disorder must be divided into two stages: initially directed toward the acute inflammatory episode and secondly treatment to lower the total body pool of uric acid during the intercritical period.

a. *Anti-inflammatory therapy*. If the diagnosis can be substantiated with aspiration of the joint and verification of the crystals by compensated polarized microscopy, indomethacin or phenylbutazone are quite effective in reducing the pain and inflammation of the acute attack. Indomethacin in doses of 100 to 200mg. during the first twenty four hours, followed by 50 to 100mg. for the next few days (or 600mg. phenylbutazone for the first twenty four hours, followed by 400mg. during the next few days), is very effective in reducing the pain and disability of this problem. If the physician is *unable* to substantiate a definitive diagnosis by indentifying a crystal, then a therapeutic trial utilizing colchicine is in order. Here, colchicine is given at hourly intervals until relief of pain or diarrhea intervenes. However, all too often the gastrointestinal side effects prevent appropriate dosage from being reached. Colchicine would be the drug of choice if the diagnosis could not be substantiated, since it is almost specific treatment in gout alone. It has been reported to be effective in the arthritis of sarcoidosis, familial Mediterranean fever, and occasionally pseudogout, but the response to therapy is most dramatic in true gout.

b. *Allopurinol* (Zyloprim®) is a useful agent in reducing the total body pool of uric acid.¹⁸ It should not be given during the acute attack, but rather saved for the period after the attack has abated. Dosages from 100 to 800mg. per day should be utilized to reduce the patient's serum uric acid to the lowest possible level. Side effects such as skin rash, hepatic reaction, or idiosyncratic drug reaction are minimal.

Uricosuric agents, such as probenecid and sulfapyrazone are useful agents also, but they should not be used in patients with renal disease.

2. *Pseudogout* or calcium pyrophosphate dihydrate deposition disease (CPPD) was first described by McCarty,¹⁹ who coined the label "pseudogout" because of its clinical resemblance to acute gout. However, at present, clinical manifestations also can be protean, and McCarty recently termed a group of patients with this disease as having "pseudorheumatoid arthritis." In this disease the acute inflammatory response is due to the deposition of calcium pyrophosphate crystals within the joint space. The treatment of the acute attack is similar to that of gout, except that we do not see a dramatic response with the use of colchicine. Aspiration of the crystals and instillation of a local long-acting steroid preparation is the treatment of choice, particularly if the attack is monarticular. At present, there is no effective method to reduce the total body pool of calcium pyrophosphate; so there is no way to prevent further attacks. Anti-inflammatory therapy is sometimes required to keep the attacks to a minimum.

CONCLUSION

At present, there is a broad spectrum of therapeutic agents to choose from in treating the rheumatic diseases. In making this decision, the following guidelines are suggested:

1. Attempt to make a specific diagnosis.
2. Determine the severity in terms of future disability, morbidity, even mortality.
3. Do not rely solely on the patient's pain; evaluate objective criteria as well.
4. If the situation allows, use the most conservative approach initially.
5. *Primum non nocere*.

After these guidelines are followed and therapy is implemented, the clinical results obtained are often very gratifying to both patient and physician. No longer should a patient be told "It's just a little arthritis—learn to live with it."

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THERAPEUTIC DRUG INFORMATION

This information is compiled by the Schwartz Inter-National
Pharmaceutic and Therapeutic Drug Information Center of the
Brooklyn College of Pharmacy, Long Island University.*

1. Do diuretics increase serum lipid levels?

Thiazide and related diuretic treatment appear to increase serum lipid levels significantly. This finding may be of considerable significance, as coronary atherosclerosis is a leading cause of death in patients treated for hypertension.

Helgeland *et al.*¹ in a study involving three hundred middle-aged men with uncomplicated mild hypertension, observed the effect of drug therapy on serum lipid levels. One hundred and fifty men were in the treatment group and 150 men served as controls. In a group treated with hydrochlorothiazide (HydroDiuril®, Esidrix®, Oretic®, Thiuretic®) alone, there was a distinct increase in serum triglyceride level.

Ames *et al.*² studied the fasting concentrations of serum cholesterol and triglycerides in sixty-three patients with uncomplicated essential hypertension. The patients were divided into two groups. One group of thirty-one patients received a lipid-lowering and calorie-restricted diet, and the other group of thirty-two patients, in addition to diet therapy, received chlorthalidone (Hygroton®). On diet therapy alone, serum cholesterol levels fell and serum triglyceride levels were unchanged. When chlorthalidone was prescribed in addition to diet therapy, serum cholesterol and triglyceride levels both increased. Thus, despite dietary restrictions, serum-lipids became raised when chlorthalidone was used as the sole drug in the treatment of hypertension.

Ames *et al.*³ in another study, measured serum cholesterol and triglyceride levels before and during treatment of 74 patients with mild primary hypertension. In 35 patients, there was a satisfactory reduction in elevated blood pressure with diet therapy alone. In the remaining 39 patients, a diuretic drug was required in addition. Twenty-five patients received chlorthalidone, 11 patients were treated with hydrochlorothiazide and three with spironolactone (Aldactone®). The use of diuretics was accompanied by an average increase in serum triglyceride levels.

In conclusion, it appears that diuretics raise serum lipid levels. This may be of considerable clinical significance, as coronary atherosclerosis is a leading cause of death in patients treated for hypertension. Further studies on long-term use of diuretics and their relationship to serum lipid levels still are needed.

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2. Please provide me with information concerning the use of timolol in the treatment of glaucoma.

Timolol (Timoptic®), a new β -adrenergic blocking agent, currently under investigation by Merck Sharpe & Dohme in the United States, may be an important breakthrough in the management of glaucoma when administered as an ophthalmic solution. It has been shown to lower intraocular pressure in normal volunteers and in patients with open-angle glaucoma.¹

Zimmerman and Kaufman¹ treated 30 patients with glaucoma with timolol solution. Significant intraocular pressure (IOP) lowering was achieved with 0.5 percent and 1.5 percent solution of the drug. At seven hours following treatment, the IOP was lowered 50 percent from the pretreatment pressure with both strengths of timolol. There were no ocular or systemic side effects detected. Visual acuity and pupil response were unchanged from pretreatment levels throughout the study.

Sonntag *et al.*² conducted a study utilizing timolol in the treatment of 19 patients with open-angle glaucoma. They found that a 14-week course of timolol therapy (0.1 percent, 0.25 percent, 0.5 percent twice daily) produced a statistically significant drop in mean IOP. Their data suggested that timolol reduces IOP by inhibiting aqueous production.

Zimmerman and Kaufman³ conducted a study utilizing a single dose of timolol solution in 20 adult patients with chronic open-angle glaucoma. This single-dose study demonstrated a dose response for this drug using concentrations of 0.1 percent, 0.25 percent, 0.5 percent, and 1.0 percent. Timolol 0.5 percent appeared to give the maximal ocular hypotensive effect; however, each concentration of the drug

*The Center serves as a source of intelligence on therapeutic and pharmaceutical information not readily available to physicians, at no charge to them, and provides this information with minimal time involvement. It is staffed by trained pharmacists; Jack M. Rosenberg, Pharm. D., Associate Professor and Chairman, Division of Clinical Pharmacy, Brooklyn College of Pharmacy, is Director and Walter Modell, M.D., Emeritus Professor of Pharmacology at Cornell University Medical College, is pharmacologist consultant. The service is available Monday through Friday from 9 a.m. to 4:30 p.m.—telephone (212) 622-8989 or 303-2735. Responses to these questions were prepared by J. M. Rosenberg, M.S., Pharm.D.; A. Bakst, Pharm.D.; P. Sangkachand, M.S., R.Ph.; Doris Lau, B.S.

produced an ocular hypotensive effect for at least 24 hours. No local or systemic side effects were discovered throughout the study.

Boger, *et al*⁴ reported a long-term observation with timolol in patients with open-angle glaucoma. They treated 37 patients with timolol 0.1, 0.25 to a maximum of 0.5 percent twice a day from one to 18 months, six for one to three months, 24 for three months to one year, and seven for over one year. The authors found that timolol produced sustained reductions in intraocular pressure over the treatment period and did not induce miosis, accommodative spasm, or annoying side effects. Systemic absorption produced a mild slowing of resting pulse rate. The authors also found that combination therapy with miotics and carbonic anhydrase inhibitors gave an additive effect whereas epinephrine and phenylephrine did not.

In conclusion, timolol appears to be an effective, safe, once-a-day topical agent for the treatment of glaucoma.

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3. Please compare the effects of dobutamine to dopamine.

Dobutamine (Dobutrex®) is a drug under investigation by Eli Lilly and is expected to be marketed in the relatively near future. Pharmacologically, dobutamine is a catecholamine that is reported to exert its effects mainly on the heart with minimal activity on the peripheral vascular system. It has been shown to produce its inotropic effects without significantly increasing heart rate or inducing arrhythmias.¹⁴

A review of the literature indicates that dobutamine may have some clinical advantages over dopamine in the treatment of low output syndromes associated with heart failure and coronary artery disease; although production of myocardial ischemia with either drug is a potential hazard when these drugs are given to patients with cardiac disease.

Ueda *et al*⁵ showed that dobutamine had a greater inotropic effect than did dopamine on the right ventricular muscle of beagle dogs. It also was shown that dobutamine had less arrhythmogenic activity than other catecholamines, including isoproterenol (Isuprel®) and dopamine, in dogs where the left coronary artery was ligated (experimental model to produce myocardial ischemia).

Loeb *et al*⁶ compared the acute hemodynamic effects of

dobutamine to dopamine in 13 patients with chronic low output cardiac failure. At dosages adjusted to achieve similar increments in cardiac output, dobutamine improved cardiac efficiency by reducing left ventricular filling pressure while dopamine increased left ventricular filling pressure. This poor response to dopamine probably was the result of its vasoconstrictive effects and illustrates the potential advantages of using a cardioselective agent such as dobutamine when the desired goal of therapy is to improve ventricular function by direct inotropic stimulation.

In a study by Stomer,⁷ dopamine was compared with dobutamine in patients with severe congestive heart failure. Dobutamine produced a distinct increase in cardiac index, while lowering left ventricular end-diastolic pressure and leaving mean aortic pressure unchanged. Dopamine also significantly improved cardiac index but at the expense of a greater increase in heart rate than occurred with dobutamine. Dopamine was ineffective in lowering left ventricular end-diastolic pressure, and increased mean aortic pressure. The authors concluded that dobutamine is an effective positive inotropic agent in patients with severe heart failure and because it has comparatively little effect on heart rate and aortic pressure, both major determinants of myocardial oxygen consumption, it may be of special value in patients with low output syndrome associated with coronary heart disease.

In conclusion it appears that dobutamine may be a favorable alternative to dopamine and other catecholamines in patients with chronic low output cardiac failure. The advantage of dobutamine is that it produces its inotropic effect without significant increase in heart rate or diastolic arterial pressure. It may produce a more favorable hemodynamic situation, has been shown to have less arrhythmogenic potential, and less of an effect on peripheral vascular resistance than dopamine.

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Selected Abstracts with Comments*

E. Coli Strains that Cause Diarrhea but Do Not Produce Heat Labile or Heat Stable Enterotoxins and Are Non-Invasive. Levine MM, *et al*—*Lancet* 1:1119 (1978).

Three classical enteropathogenic *E. Coli* strains isolated from infants with diarrhea (epidemic) were neither enterotoxigenic nor enteroinvasive by sophisticated assay. The strains, when fed to volunteers in high numbers, caused diarrhea. The mechanism of induction of diarrhea by these strains is presently unknown.

Comment: Bacterial gastroenteritis recently has been understood better. Some organisms cause diarrhea by invasion of mucosa (e.g., shigella), others by toxin production (e.g., cholera). *E. Coli* seem to be "swingers" in that they can cause diarrhea by either method (depending upon the strain). Historical enteropathogenic *E. Coli* (newborn outbreaks) seem to be neither enteroinvasive nor enterotoxigenic. But, despite recent statements to the contrary, they do indeed cause diarrhea and are not merely associated and unrelated. Current hospital laboratory typing of *E. Coli* only identifies such historical strains and not the more common invasive or toxigenic ones. Obviously, although such typing cannot prove causality, knowing that such a strain is present is of some value. Hopefully, assays for toxigenicity and invasiveness will become commercially available in the near future to allow us a better ability to diagnose. We also will need a rapid test for the more common rotavirus and parvovirus diarrheas. (R. H. Rapkin, M.D.)

Predicting School Failure. Information Available at Birth. Ramey CT, *et al*—*Am J Ment Def* 82:525, (1978).

The authors have used information available from birth certificates to predict the psychological and educational status of approximately 1,000 randomly sampled first grade children. Analysis revealed that psychoeducational status in the first grade, meaning the need for special services, could be predicted, from a combination of birth order, race, educational status of the mother, the month prenatal care began, survivorship of older siblings, and the child's legitimacy. Of all, race and educational status of the mother, were most helpful.

Comment: The authors indicate how a simple ongoing risk registry might be set up to indicate those children who will lag behind in psychoeducational functioning and who might be considered for early intervention services.

(A. Katcher, M.D.)

Perspective on Chronic Nonspecific Diarrhea. Dietary Management. Cohen S, *et al*—*Pediatr* 61:808-809 (1978).

While studying infants with chronic nonspecific diarrhea (CNSD), the authors made the serendipitous observation that the diarrhea ceases during fat excretion studies. They found this to be related to the daily minimum intake of 50 gms of dietary fat required for the performance of 72-hour stool fat excretion studies undertaken to exclude malabsorption states from the differential diagnosis. Subsequently, a therapeutic diet containing 30 to 50 percent of its calories in the form of fat (preferably polyunsaturated) resulted in resolution of symptoms in more than 90 percent of patients with chronic nonspecific diarrhea. It was further observed that CNSD occurred largely in two groups of patients: (1) following a mild respiratory illness in which oral fat intake was reduced and calorie requirements increasingly met with high carbohydrate foods, and (2) a smaller number of infants who received unsupervised parenterally prescribed low fat diets to reduce the risk of later arteriosclerotic disease. The authors invoke, as explanation, the increased intestinal motility caused by hypertonic carbohydrate beverages and the role of fat in delaying gastric emptying and in slowing intestinal transit time.

Comment: It is interesting that *Pediatrics* published a commentary like this before any original article with substantiating data has appeared. Many important aspects are missing, such as the number of patients treated, the actual composition of the diet, the duration of treatment, and the incidence and nature of untoward side effects, if any. Nevertheless, this represents the first new idea in a long time about a relatively common, therapeutically frustrating (although benign) condition. It sounds like a sensible approach; more details are awaited eagerly. (N. Sissman, M.D.)

Passive Transfer of Diabetes Mellitus from Man to Mouse. Buschard K, *et al*—*Lancet* 1:910 (1978).

Lymphocytes extracted from peripheral blood samples from each of six patients with newly diagnosed insulin-dependent diabetes mellitus were transplanted into athymic nude mice (incapable of rejecting transplanted cells or tissues). At one or more sampling times (in the thirty-day

*Abstracted from "Pediatric Department Newsletter," RMS, Vol. 2, No. 9-10 (June-July 1978). Selections are made and original comments prepared by Richard H. Rapkins, M.D., Professor of Pediatrics, RMS, CMDNJ, and his associates.

study), blood-sugar was higher in the mice which had received lymphocytes from diabetic patients than in the control mice which had received lymphocytes from non-diabetic donors. Blood-sugar concentrations reached 260 mg/dl in some mice in the experimental group.

Comment: In many previous studies the finding of lymphocytic infiltration of islets of Langerhans in patients with juvenile diabetes had suggested that aggressive sensitized lymphocytes are involved in diabetogenesis. This study directly demonstrates the involvement of lymphocytes lending further support to the theory of immunologic pathogenesis of insulin-dependent diabetes mellitus.

(P. Papageorgiou, M.D.)

Home Monitoring of Blood-Glucose. Sonksen PH, *et al*—*Lancet* 1:729 (1978).

Self-Monitoring of Blood-Glucose. Walford S, *et al*—*Lancet* 1:731 (1978).

These two articles describe the experience of two large British diabetic clinics utilizing frequently obtained blood glucose measurements determined by dextrosticks and reflectometers on capillary blood. Using this technique the pattern of blood glucose changes can be documented throughout the day on ambulatory diabetics engaging in normal activity. Both studies demonstrated how vastly improved diabetic control can be obtained using this technique and appropriate alterations in insulin type, dosage, and timing.

Comment: The data supporting the relationship between the degree of diabetic control and progression of micro-vascular disease are becoming more conclusive. This technique offers advantages over determination of hemoglobin A1C (which increases with hyperglycemia) in that it not only detects poor diabetic control, but it also helps the patient to make rational changes in his therapeutic regimen. It seems more sophisticated and less inherently error-prone than even quantitative glucose excretion and is far superior to traditional pre-prandial urine fractionals in adjusting the insulin-diet relationships.

(S. Kleeman, M.D.)

Renal Scarring and Vesico Ureteric Reflux (VUR). Shah KJ *et al*—*Arch Dis Child* 53:210 (1978).

This is a retrospective study of children with urinary tract infection (UTI) and VUR. It demonstrated that for the population studied, more severe VUR was associated with: (1) age at diagnosis (most common in infancy), (2) higher frequency of renal scars, and (3) deterioration or new appearance of radiographic renal scars.

The authors demonstrated that (even in the school-age group) severe VUR could accompany a normal IVP and that progressive scarring could occur both after age five and in the absence of "confirmed" UTI.

Comment: This study strengthens the documentation of the association between renal parenchymal scarring and VUR and argues strongly for the inclusion of voiding cystourethrogram (VCUG) in the initial evaluation of a child with UTI (even with a normal IVP). I recommend a VCUG and IVP in all children with UTI under five years of age. In school-aged children, an abnormal IVP obtained during investigation of the first UTI or recurrent UTIs with any hint of clinical pyelonephritis also should be indications for a study to determine the presence and severity of VUR.

(S. Kleeman, M.D.)

Educational Costs to Hospitalized Patients. Martz EW, *et al*—*J Med Ed* 53:383 (1978).

The authors' study compared patterns of care for patients discharged from two teaching floors and two comparable non-teaching floors of the Wilmington (Delaware) Medical Center. The length of stay was almost identical. The average number of final diagnoses per patient was essentially the same as was the number of consultations. What was noteworthy was that the charges generated on the teaching floors in the areas of supplies, pharmacy, radiology, and laboratory were much greater than on the non-teaching floors. In the laboratory area over two and a half times as many charges were generated on the teaching floors. It appears that the charges on patients who died were much higher per day than those who lived and the discrepancy between teaching and non-teaching patients was even larger.

Comment: There are hidden costs to a teaching program. This study attempts to quantify some of them. These costs currently are paid for by the patient on the assumption that the medical care is better on a teaching unit. Whether or not the assumption can be verified is not known. It is certainly true, however, that the patients are not offered a choice.

(A. Katcher, M.D.)

Comment: Unfortunately, comparability of patients was not assured in this study. In many hospitals with teaching and non-teaching services, the more complex patients are sent to the teaching service. More rigorous studies will need to be done to assess the "whys" of additional costs of teaching services. Simply overtesting and overtreating are not to blame unequivocally.

(R. H. Rapkin, M.D.)

Fatal Rotavirus Gastroenteritis. Carlson JAK, *et al*—*Am J Dis Child* 132:477 (1978).

Rotavirus may be the most common etiologic agent of gastroenteritis in infancy. "Winter vomiting sickness" is often caused by rotavirus. During five years in Toronto, 21 patients (mean age 11 months) with rotavirus gastroenteritis died of their disease. Most of the patients died within three days of disease onset and had profound dehydration often with hypernatremia. Some had been seen by physicians and subsequently became very ill. All of the fatalities occurred between December and May. Extremely rapid dehydration was the likely problem.

Comment: Viral gastroenteritis may be severe. Rapid deterioration may occur. Infants with gastroenteritis need careful assessment and reassessment. Hypernatremia may make clinical dehydration less obvious. Daily weights, urine, specific gravities, and careful reexamination are essential.

(R. H. Rapkin, M.D.)

Nebulized Racemic Epinephrine by IPPB for the Treatment of Croup. Estley CR, *et al*—*Am J Dis Child* 132:484 (1978).

In a well-controlled study of viral croup patients who received racemic epinephrine by IPPB were helped compared to controls. The help was short-lived, i.e., there was only a short response to therapy and then return to distress. Therefore, therapy will need to be repeated and the patient should be hospitalized. Whether repeat therapy remains effective has not been studied; whether IPPB with epinephrine shortens hospitalization has not been studied.

Comment: If a child with croup is hospitalized and if he does not have epiglottitis and if he looks like he may need to be intubated (rising pCO₂s), then I would try IPPB with

epinephrine (racemic or 1 percent aqueous are equivalent). If there is a response I would repeat as often as necessary to prevent intubation. If no response I would intubate.
(R. H. Rapkin, M.D.)

The Smallest Preterm Infants. Kopelman AE—*Am J Dis Child* 132:462 (1978) (editorial).

A review of current literature suggests that two-thirds of infants of more than 28 weeks gestational age will survive and 80-90 percent will be normal (be free of handicapping disabilities) if the infants are handled as we are capable of handling them. The cost per infant is approximately \$40,000.

Comment: We can treat these infants if we want to. We can't be ambivalent since if we try a little the infant will survive but be handicapped and cost a lifetime of \$40,000s. If we don't try at all, these infants will die and costs will be low, but how can we decide to do that in a small, otherwise normal infant. The answer, I think, is to do our best and that means state-of-the-art care. Referral to tertiary centers of such tiny babes is important. Referral of mothers threatening to deliver such infants is perhaps more effective.
(R. H. Rapkin, M.D.)

Prognosis in Children with Febrile Seizures. Nelson KB, et al—*Pediatr* 61:720 (1978).

Behavior Disturbance, Phenobarbital and Febrile Seizures. Wolff SM, et al—*Pediatr* 61:728 (1978).

Febrile Seizures: An End to Confusion. Freeman JM—*Pediatr* 61:806 (1978) (editorial).

The prognosis of febrile seizures is good. Risk factors are identifiable both for recurrence and neurologic outcome. Phenobarbital given to prevent recurrence (continuous prophylaxis) leads to hyperactive behavior in a large minority of patients.

Comment: These articles are must reading for all who care for children. In a recent discussion even the most ardent devotee of universal prophylaxis stated that he was compromising on the basis of these data. Most patients who have a febrile seizure need nothing but observation. Another victory for the antimanipulators. (R. H. Rapkin, M.D.)

Prevention and Therapy of Serous Otitis Media by Oral Decongestant: A Double Blind Study in Pediatric Practice. Olson AL, et al—*Pediatr* 61:679 (1978).

Both prevention with decongestant of serous otitis media in acute otitis media and treatment of serous otitis media with decongestant do not work.

Comment: There are now at least five separate studies which conclude that decongestant or antihistamine-decongestant does not prevent otitis media or reduce the incidence of serous otitis media or treat same effectively. Let's stop wasting our patients' money. These diseases are frustrating and our therapies don't always lead to cure but we should discard ineffective therapies and look for better ones. Old ways die hard. We feel we have to do something. Parents may be taught to observe and wait. (I have been following a number of patients with serous otitis media and doing nothing but tympanometric confirmation of the problem and observing. The parents are comfortable with waiting and observing. Most of the children clear spontaneously in four to eight months.)
(R. H. Rapkin, M.D.)

Pathogenesis of Fever in Man. Wolff SM, et al—*N Engl J Med* 298:607 (1978).

Circadian temperature rhythm is consistent for each person and is usually difficult to disturb. Body temperature is controlled by a thermoregulatory center in the hypothalamus. Endogenous pyrogen produced by neutrophils, monocytes, eosinophils can cause fever and lymphocytes which produce lymphokines may lead to production of such pyrogens. Leukocytes release pyrogen during and after phagocytosis. Endogenous pyrogen induces synthesis of prostaglandins which are central transmitters to the thermosensitive neurons leading to an increase in their firing. Inhibitors of prostaglandin synthesis (ASA) reduce fever. "The ability of an antipyretic to reduce fever is proportional to its ability to inhibit prostaglandin synthesis . . . antipyretics do not lower body temperature in human beings unless fever is present . . . they do not affect the body temperature of subjects in whom the normal daily temperature is above the mean or exhibits a wide circadian range."

Comment: This review is very helpful to those of us dealing with "low-grade" fevers. The implication for the clinician is that a low-grade fever unresponsive to aspirin is a normal variant.
(R. H. Rapkin, M.D.)

Indications for Early Exchange Transfusions in Patients with Erythroblastosis Fetalis. Weinberg RP, et al—*J Pediatr* 92:789 (1978).

Cord blood values failed to predict severity of hyperbilirubinemia. There was no reliable way to predict severity of jaundice except by careful following of serum bilirubins. Caution is indicated in aggressive early intervention with exchange transfusion both from the point of view of allowing the baby to stabilize and complete his immediate adaptation to extrauterine life and to determine ultimate need. Early exchange transfusion should be reserved for infants with impaired oxygen-carrying capacity and a limited emergency exchange transfusion may be necessary for such infants.

Comment: The old Allen and Diamond criteria for Rh erythroblastosis have now been reevaluated in light of current methods of therapy which include phototherapy and phenobarbital. The best conclusion to be drawn is that prediction of exchange transfusion need is not possible and that such procedures should be done on present indication, not future possible need.

Reye's Syndrome. DeVivo DC—*Neurol* 28:105 (1978) (editorial).

Reye's syndrome is second most common cause of virus associated CNS disease (encephalitis is number one). It is seen most commonly in children, more frequently in the suburbs and has been associated most frequently with varicella and influenza B. The pathology is characterized by mitochondrial degeneration in all tissues studied. This mitochondrial injury is probably primary in all tissues and is responsible for hypoglycemia, hyperammonemia, and the cytotoxic and interstitial cerebral edema. The origin of the mitochondrial injury is not known. Therapy early may be helpful. Adequate glucose and oxygen need to be delivered to tissues. Monitoring and manipulating therapeutically intracranial pressure (subdural bolt or ventricular catheter) seem to be advantageous but no controlled studies have been done.



When is a chest pain a heart attack?


Often, determining the cause of a chest pain is difficult. So how can a doctor tell when it's a heart attack?

The American Heart Association is supporting research to help doctors identify heart attacks as early as possible so the victims can receive fast, effective aid.

One research method is myocardial scintigram. It allows accurate diagnosis of heart damage without catheters, without the injection of dyes.

With it, doctors can actually look inside a patient's body to evaluate the heart's condition. They can see a cross-section of the heart and its chambers and can determine the heart's effectiveness as a pump. If there is heart damage, the doctors can see exactly where—and how extensive—it is.

Myocardial scintigram is one of the techniques pioneered through research supported by the American Heart Association.

Please give generously to the American Heart Association 

WE'RE FIGHTING FOR YOUR LIFE

Trustees' Minutes September 17, 1978

A regular meeting of the Board of Trustees was held on Sunday, September 17, 1978, at the Executive Offices in Trenton. Detailed minutes are on file with the secretary of your county medical society. A summary of significant actions follows:

Emanuel M. Satulsky, M.D. . . . Stood for a moment of silent prayer in tribute to the memory of Emanuel M. Satulsky, M.D., 178th President of MSNJ, former member of the Board of Trustees, and currently AMA Delegate, who died on September 10, 1978.

. . . Adopted the following memorial resolution in honor of Dr. Satulsky:

Emanuel M. Satulsky, M.D.
1909-1978

Whereas, Almighty God has summoned from our midst his good servant and our beloved colleague, Emanuel M. Satulsky, M.D.; and

Whereas, as a Fellow of the Medical Society of New Jersey, a member of the Board of Trustees, a member of the AMA Delegation, a member of the AMA Council on Constitution and Bylaws, a member of the Judicial Council of the Medical Society of New Jersey and numerous other councils and committees of the Medical Society of New Jersey, Doctor Satulsky rendered uniformly high and valuable service to the Medical Society of New Jersey and the people of our state; and

Whereas, by his industry, understanding, and dependability he won the respect and esteem of all who knew him; now therefore be it

RESOLVED, that the Medical Society of New Jersey honoring Emanuel M. Satulsky, M.D., in death as in life, records its profound grief at his passing; and be it further

RESOLVED, that a copy of this resolution be spread upon the minutes of this meeting and another copy, suitably prepared, be presented to his bereaved family in token of heartfelt sympathy.

. . . Authorized the customary contribution to the Medical Student Loan Fund in Dr. Satulsky's memory.

AMA Conference on Dynamics of Conflict Resolution . . . Authorized the atten-

dance of three of its members, Drs. Alessi, Bernstein, and Krueger, to attend the above-named conference in French Lick, Indiana, October 27-28, 1978.

Association for Hospital Medical Education of New Jersey Meeting . . . Authorized MSNJ's co-sponsorship and financial support (\$500) of a meeting of the Association for Hospital Medical Education of New Jersey to be held April 4, 1979 at CMDNJ-Rutgers.

Proposed Rule Concerning Termination of Exemptions from Licensure Requirements . . . Noted that a public hearing will be held September 27 at Essex County Community College concerning this proposed rule, which would require that unlicensed physicians in state or county institutions, or state agencies with patient care responsibility, must satisfy preliminary requirements for licensure and pass the earliest FLEX examination given following employment. Failure to take or to pass the examination would result in automatic termination of license exemption.

New Headquarters . . . Noted that use variance was obtained from the Lawrence Township Board of Adjustment on September 13. Contractors are proceeding with necessary renovations, and MSNJ staff offices may be ready for occupancy in December.

Professional Liability Subpanels . . . Noted that amendment of *Rule 4:21* (Professional Liability Claims Against Members of the Medical Profession), permits pre-trial mandatory panel hearings in litigation involving allegations of medical malpractice, and makes it the medical profession's responsibility to maintain a pool of medical manpower to staff such panels. County medical societies were asked (August 22) to supply current lists of 15 to 25 physicians willing to serve. Response had been poor, and the Board's assistance has been sought in emphasizing the importance of supplying the requested information.

Medical Society of New Jersey Student Association . . . Received a report from Mr. Leonard Bielory, liaison representative, which contained a recommendation that MSNJ consider providing secretarial service for MSNJSA. Duties would include maintaining an up-to-date membership list, data cards, obtaining related information for use of students, and so on.

. . . Referred the recommendation to the Committee on Finance and Budget for consideration and study.

Legislation . . . Approved the Council on Legislation's position on bills of medical import, with the exception noted.

S-407 Hagedorn—Mental Health Services
Creates a ten-member commission to study and recommend extensive revisions to the mental health services' delivery system in New Jersey as well as an in-depth analysis of the impact of federal funding. **ACTION DEFERRED**, pending further information from the Council on Mental Health.

S-440—Dodd—Catastrophic Health Insurance
Creates a catastrophic health insurance fund to reimburse individuals for catastrophic costs incurred because of injury or illness. The fund is to be capitalized initially by the State who then would bill private carriers for their insureds. The carriers then would be permitted to recapture losses by placing surcharges on their policies. All of the mechanism is to be monitored by the Insurance Department and administered via a "Health Insurance Underwriting Association." **Disapproved**, because, although MSNJ approves the concept of catastrophic health insurance, this bill would change the insurance companies into fiscal intermediaries, if not sound fiscally, and could prove counterproductive.

S-523—Feldman—Data Privacy
A State version of the Federal Privacy Act, this bill grants individuals access to their personal information held in State government files. At the same time it obligates the State to prevent the misuse of private or confidential information and makes the government subject to civil suit. An information data system would be created to classify the data being retained and stored by the State. **APPROVED**

S-653—Hagedorn—Involuntary Commitments
Restructures existing laws to provide that:
1. The Boards of Freeholders shall designate one or more screening centers within their counties or on an inter-county basis as the Department of Human Resources may ap-

prove.

2. The screening service shall provide examinations, diagnoses evaluation, and emergency treatment in accordance with departmental regulations.

3. Involuntary commitments are to be certified to by two psychiatrists or one psychiatrist and one licensed physician or a psychiatrist and a psychologist.

4. The screening or commitment process is to be initiated by a sworn document signed by an immediate family member, next of kin, physician, psychiatrist, county medical examiner, social worker, police official, county prosecutor, or a county or municipal welfare director.

5. Screening Services shall hold persons determined to be dangerous for no more than seventy-two hours before the involuntary commitment mechanism must be complied with.

6. Patients being admitted to screening centers or institutions have a detailed list of rights including the immediate right to counsel. **ACTION DEFERRED**, pending further information from the Council on Mental Health.

S-677—Lipman—Hereditary Disorders Act

This bill requires the Department of Health to set up a program of assistance for New Jersey citizens who suffer from hereditary disorders such as Cooley's anemia, cystic fibrosis, sickle cell anemia, galactosemia, hemophilia and Tay Sachs disease. The program would include the development of:

1. Standards for detecting hereditary disorders;
2. Voluntary testing and genetic counseling services;
3. Laboratory services;
4. An educational program concerning hereditary disorders;
5. Curriculum guidelines (in cooperation with the Commissioner of Education) concerning the "nature, detection, prevention, and treatment of hereditary disorders"; and
6. Efforts (in cooperation with the Commissioner of Insurance) to eliminate "arbitrary and unreasonable discrimination against carriers or victims" of these disorders in insurance policies. **APPROVED**

Note: The Board referred S-677 back to the Council on Legislation, withholding approval because present wording of the descriptive statement implies that the bill is applicable to all hereditary diseases. (Italics in line 5 of the description indicate suggested amendment.)

S-826—Dodd—PKU Testing of Newborns

This bill has no effect on the existing mandated test system. **NO ACTION**

S-828—Dodd—Dental Anesthesia

Prohibits dentists from administering a local or general anesthesia unless they have passed a course in anesthesia which has been approved by the New Jersey State Board of Dentistry. **ACTION DEFERRED**, pending further information from the New Jersey Dental Association and the New Jersey State Society of Anesthesiologists.

S-838—Dodd—Licensing and Regulating of Respiratory Therapists

Provides for the licensing and regulation of respiratory therapists and technicians under the auspices of the State Board of Medical Examiners. Provision of services other than under the direction or supervision of a physi-

cian shall be cause for revocation of licensure. **DISAPPROVED**, because the Society is not in favor of further individual licensure of ancillary personnel that must be relied upon by the practicing physician. The answer to the problem is not to license them individually, but to recognize the right of the physician to utilize those personnel whom he recognizes as competent and for whom he assumes responsibility.

S-846—Parker—Breath and Blood Determinations—Persons Suspected of Driving Under the Influence of Alcohol or Other Intoxicating Drugs

Grants immunity to physicians who take samples or make tests at the requests of police when done in a medically acceptable manner, but not forcibly and against physical resistance. **APPROVED** (This bill is similar to A-759—Hurley and the Council directed that a letter be forwarded to each sponsor recommending that the bills be combined and reintroduced as one complete bill.)

S-865—Dumont—Utilization Review

Permits all insurance carriers to examine the same information and medical data that are available to the utilization review committee and the attending physician. **DISAPPROVED**, because this bill would endanger the patient-doctor confidentiality mechanism.

S-890—Gagliano—Risk Registry for Handicapped Children

Provides for the maintenance of a risk registry for "handicapped children" (under 21 with organic disease, defect, or condition which may hinder normal growth and development) and for "high risk children" (any infant liable to become handicapped under definition by rules and regulations of the Public Health Council).

Physicians (doctors of medicine, osteopathy, dentists, chiropractors, optometrists, and podiatrists) along with psychologists, nurses, and midwives shall file confidential reports with the registry detailing the symptoms of the handicap or of the high risk, within thirty days of diagnosis. **DISAPPROVED**, because this subject is already covered by existing legislation.

A-247—Croce—Regulation of Insurance Rates

Would amend the insurance statutes to allow carriers to alter rates without the prior approval of the Commissioner. The Commissioner could "disapprove a rate" if the carrier does not file with the Department supportive documentation within thirty days of the effective date of the rate. **APPROVED**

A-426—Hardwick—Uniform Anatomical Gift Act

Requires the Division of Motor Vehicles to provide a place on the driver's license where the individual can designate himself as a donor under the Uniform Anatomical Gift Act. **APPROVED**

A-458—Jackman—Professional Boards

Provides uniform enforcement powers and procedures for professional boards. Grants the Attorney General the right to concurrent jurisdiction and also to override a given board decision when contrary to law or the weight of evidence contained in the record before the Board. **NO ACTION**

A-507—DiFrancesco—Child Abuse

Would make medical evidence of the existence of venereal disease in a child under 12 a rebuttable presumption of child abuse or neglect. **DISAPPROVED**, because this bill would presume guilt and would, therefore, be

considered unconstitutional.

A-514—Villane—Residential Facilities for Psychiatric Patients

Requires the Department of Human Services to inform the local health agencies whenever it places former psychiatric hospital patients in a local residential facility. **APPROVED**

A-521—DiFrancesco—Involuntary Commitments for Mental Disorders

Same as S-653, **ACTION DEFERRED**, pending further information from the Council on Mental Health.

A-622—Herman—Prescription Drugs

Amends existing law to permit patients to possess ten days' supply of a controlled dangerous substance in a container other than the original, provided the patient carries with him a writing provided by his physician detailing—the name and address of the dispensing practitioner, the prescription record identification number, the name, address, and registration number of the prescriber, the name of the substance, and the directions for its use. **APPROVED**

A-639—Baer—Medical Reports

Makes it a misdemeanor for a physician intentionally to supply a misleading medical report which is submitted to any judicial or administrative hearing in this State or used in negotiations seeking a settlement in any such proceeding. **APPROVED**

A-668—Pellecchia—Medicaid

Amends the Pharmaceutical Assistance to the Aged Program to include the disabled (i.e., those receiving Social Security total disability benefits.) **NO ACTION**

A-708—Shapiro—Expunging of Mental Health Commitment Records

Provides that patients must be discharged in an improved condition or in a condition of remission before being eligible for expungement proceedings. **ACTION DEFERRED**, pending further information from the Council on Mental Health.

A-745—Burstein—Criminally Insane Persons

Makes determination of fitness for trial and also the continuing defense of insanity a purely judicial determination. If, however, the individual is ruled sane at the time of trial the jury then rules on the defense of insanity at the time of the commission of the offense. Any time the defense of insanity at the time of the commission of the crime is the final determination, the State may request a sixty-day confinement for observation following which a hearing will be held to determine whether or not the individual can be released without being a danger to himself or others. That hearing is a judicial determination. **ACTION DEFERRED**, pending further information from the Council on Mental Health.

A-747—Cowan—Medicaid

Makes disabled persons (eligible for benefits of permanent disability under the SSA) eligible for the State Pharmaceutical Assistance Program. **NO ACTION**

A-759—Hurley—Motor Vehicles

Provides for implied consent to the taking of blood and urine samples for chemical analysis to determine drug content. Samples may not be taken forcibly and against the physical resistance of the person being arrested. **APPROVED** (This bill is similar to S-846—Parker and the Council directed that a letter be forwarded to each sponsor recommending that the bills be combined and reintroduced as one complete bill.)

A-775—Bornheimer—Nursing Services

Provides for elective group health insurance coverage of the fee-for-service nursing, provided the nurse is not a salaried employee, for the duties performed. **APPROVED**

A-776—Bornheimer—Nursing Services

Same as A-775 except it extends coverage availability under medical service contracts. **APPROVED**

A-777—Bornheimer—Nursing Services

Same as A-775 except it applies to individual health insurance contracts. **APPROVED**

A-800—Orechio—Clinical Laboratory Services

Provides that laboratory services must be billed directly to patients except when billed to:

- a. the legal representative of services;
- b. the insurance carrier designated by the recipient;
- c. a hospital on behalf of the recipient;
- d. an industrial firm on behalf of its employees;
- e. a trade union health facility for its registered patients;
- f. governmental agencies on behalf of the recipient;
- g. a registered laboratory to another laboratory for actual services rendered;
- h. a physician who discloses to the recipient the name of the laboratory, the amount paid, and the processing or procurement charge.

NO ACTION

A-817—Orechio—Eye and Ear Examinations of School Children

Mandates Boards of Education to employ one or more optometrists to be known as the "school vision examiners" and one or more physicians to be known as "school hearing examiners." (The hearing examiners also may be the medical inspectors) **DISAPPROVED**, because the school physician already has the obligation to screen for physical defects including impairment of vision and hearing.

A-832—Orechio—Eye Examinations of School Children

Mandates Boards of Education to employ one or more optometrists or physicians as "school vision examiners." **DISAPPROVED**, because the school physician already has the obligation to screen for physical defects including impairment of vision.

A-864—Brown—Smoking

Requires health care facilities to set aside not less than 30% nor more than 50% of total patient rooms as "no smoking allowed" rooms. **APPROVED**

... Approved a recommendation from the Council on Legislation that the following bills be "noted and filed" as not being of intimate concern at this time:

S-446—Merlino—An Act Concerning the Provision of and Payment for Medical Services and Establishing a Hospital Rate Setting Commission

This version gives Commissioner Sheeran and Commissioner Finley their vote back on the Health Care Administration Board. It establishes a five-member rate-setting Commission. Two of the five will be the Commissioners of Health and Insurance—ex-officio with votes.

S-493—Maressa—Health Care Facilities

Transfers to the Department of Insurance those regulatory acts which produce recog-

nizable charges via insurance issued by hospital service corporations. Further, all rate regulations, budget approvals, and review activities would become an Insurance Department function.

S-707—Skevin—Cigarette Tax (Cancer Research)

Places an additional tax of .01 cent on each pack of cigarettes sold in New Jersey. The proceeds to be utilized within the State for cancer research at facilities certified by the Commissioner of Health.

S-781—Zane—Medical Expenses Under Auto Liability Insurance Policies

Would amend existing law to make medical expense benefits an optional coverage under the no-fault auto insurance act.

A-659—Orechio—Emergency Telephone System

Authorizes the Department of Transportation to install and maintain a motorist emergency communications system along the Interstate and State highways in New Jersey.

... Assumed a position of "no action" on a draft of proposed legislation on a Mobile Intensive Care Unit (1978) pending submission of final draft with clarification of term "emergency medical technicians" rather than "paramedics" as contained in the first draft.

... Considered a letter received from the Legislation Committee of the New Jersey Occupational Therapy Association on A-83—Occupational Therapy Licensing Act—advising that a clause will be included in the bill which will require a physician's referral and/or consultation to initiate occupational therapy services, and requesting MSNJ's endorsement. (On April 16 the Board took the position of disapproval of A-83, stating the bill lacked proper physician direction.) MSNJ is on record as opposing further individual licensure of ancillary personnel (Bill S-838—Licensing and Regulating of Respiratory Therapists); therefore, to maintain a consistent posture, the Board agreed that the proposed amendment would not alter MSNJ's position of disapproval of A-83.

Need for a Basic Medical Science Structure in southern New Jersey ... Reviewed the Council on Medical Services' position paper on the subject as well as a minority report from Arthur Bernstein, M.D., chairman of Committee on Medical Education, and by a show of hands' vote, it was agreed: (1) there is a need for an increased enrollment by 100 students to reach the goal of 400 new physicians per year; (2) existing basic medical science facilities in Piscataway and Newark should be expanded; and (3) the present concept of a "school without walls" in southern New Jersey should prevail.

Committee on Maternal and Infant Welfare ... Approved the committee's recommendation that its name be changed to the Standing Committee on Maternal and Child Care.

AMA Maternal and Child Care Committee ...

Received as informative a report by Peter A. Beaugard, M.D., chairman of MSNJ's Special Committee on Maternal and Infant Welfare on his attendance at the meeting of the AMA Maternal and Child Care Committee in Phoenix, Arizona on May 27-28, 1978.

Committee on Medical Defense and Insurance ...

Received as informative the report of the reorganization meeting of the Standing Committee on Medical Defense and Insurance on June 28.

Reimbursement of President and Chairman of the Board ...

Considered the report of the Special Committee on Long Range Planning and Development concerning Resolution #23—"resolveds" of which read as follows:

"RESOLVED, that the President of the Medical Society of New Jersey's stipend be increased to \$75,000 a year for the year he or she is in office and \$25,000 for the first year out of office; and be it further

"RESOLVED, that the Chairman of the Board of Trustees of the Medical Society of New Jersey be given an annual stipend of \$25,000; and be it further

"RESOLVED, that these stipends are to help defray the physicians' loss of income during his or her tenure."

... Took the following actions:

1. Referred the recommendation of the Special Committee on Long Range Planning and Development to the Committee on Finance and Budget and directed that the duties of the President should be redefined if so large a salary is to be considered.
2. Directed the Committee on Finance and Budget to consult with past MSNJ presidents to determine the actual cost of their year in the presidency.
3. Directed the Committee on Finance and Budget to determine the actual cost to the membership if annual stipends to the President and Chairman of the Board are authorized.
4. Directed the Committee on Finance and Budget to submit its recommendations for Board consideration.

The Journal ... Received as informative the report from Dr. Krosnick on the readership survey.

... Approved the new advertising rates for *The Journal* effective January 1, 1979, representing a 10 to 16.6 percent range of increase.

... Noted that the new graphics resulted in a savings of approximately \$2,000 per issue, March to August inclusive (excluding the July issues).

... Noted limiting the publication of the CME calendar to cover only the two months following the month of issue and initiating a new feature "CME Classified Ads."

American Hospital Association Regional Advisory Board ... Received as informative, a written report from John S. Madara, M.D., on his attendance at the Association's meeting held July 20-21, 1978 in Cooperstown, New York.

American Hospital Association ... Received as informative, a written report from John S. Madara, M.D., on his attendance at the AHA meeting held September 12, 1978 in Anaheim, California.

Health Care Administration Board ... Received as informative a written report from Frank M. Campo, M.D., on his attendance at the August 3, 1978 meeting of the Health Care Administration Board in Trenton.

State Board of Medical Examiners ... Heard an oral report from George L. Benz, M.D., on his attendance at the September 13, 1978 meeting of the State Board of Medical Examiners in Princeton.

Medical Assistance Advisory Council ... Directed, upon receipt of request from the Division of Medical Assistance and Health Services, New Jersey Department of Human Services, for MSNJ physician participation, that Harvey J. Shwed, M.D., and Seymour Charles, M.D., be asked to represent the Society on the Council.

Commission on Professional Health Services ... Instructed the President to send a communication to the Governor reflecting the objection of the New Jersey Orthopaedic Society to the fact that there is no physician representation on the Commission on Professional Health Services.

Note: This commission was established by the Governor in July 1977 with the charge to

develop recommendations to counteract the potential loss of physician manpower resulting from the enactment of the Federal Health Professions Education Assistance Act of 1976 (P.L. 94-484) which places restrictions on the immigration of foreign physicians.

AMA Draft Resolution on Cost Containment ... Voted to endorse the AMA's draft resolution on cost containment urging physicians to keep fee increases in line with the annual increase in the cost of living and to cooperate in restraining increases in hospital costs without arbitrary limits or government intervention.

Ethics Committee ... Received as informative a communication from the Secretary of the New Jersey Orthopaedic Society inviting MSNJ and component societies to submit problems or questions for review to a newly formed Ethics Committee.

AMA Council on Constitution and Bylaws ... Directed that Frank J. Hughes, M.D., be nominated to fill the unexpired portion (1980) of Dr. Satulsky's term on the AMA's Council on Constitution and Bylaws.

Pharmaceutical Assistance to the Aged ... Referred to the Committee on Medicaid, for discussion with the appropriate State agency, the problem Dr. Mineur encountered when pharmacists issued only a month's supply of medication to patients under this program. If the dosage had to be increased, exhausting the patient's supply before the end of the month, the patient was billed for an additional prescription.

CMDNJ Notes*

Stanley S. Bergen, Jr., M.D.
President

As a further step in helping to ease the shortage of health manpower in New Jersey, a new physical therapy program, the first of its kind in the state, currently is being offered jointly by CMDNJ and Kean College. The twenty students in the inaugural class are working toward a baccalaureate degree, with two years of pre-professional studies at Kean and two years of practical training in clinical settings under the supervision of the CMDNJ-School of Allied Health Professions, Newark.

After comprehensive exposure to the theory and use of therapeutic techniques such as exercise, light, heat, ultrasonics and massage, those who complete the program will be able to work under physicians' supervision, in hospitals and rehabilitation centers, with orthopedically impaired patients.

The introduction of this physical therapy program demonstrates the School's two major goals: to fill identified gaps in New Jersey's health care system, and to utilize the vast health education resources of CMDNJ in cooperation with other institutions of higher learning.

While educating more physicians and dentists is one answer to easing the shortage of health manpower in New Jersey, it does not solve the whole problem. Admittedly, the training of medical and dental students is an expensive and lengthy process, and the professional's expensive and hard-won skills would be wasted if he spent too much of his time performing tasks which could be assumed by less broadly trained specialists.

Serving as physician and dentist "extenders," the allied health professionals free the doctors and dentists for the more sophisticated aspects of health care. Thus, the use of auxiliary personnel means that the doctor can treat more patients.

Students at the CMDNJ-School of Allied Health Professions are involved in a variety of disciplines. Some receive only a year of training, while others pursue degree programs up to the graduate level. Some work directly with the physicians and/or dentists in their offices and clinics, have direct contact with patients. Others work behind the scenes to perform tasks which facilitate diagnosis and treatment. Programs currently offered by the school include:

Cytotechnology—a one-year program which trains students to prepare cell samples for diagnosis in clinical laboratories.

Dental Assisting—a year long program which focuses on chairside aid to the dentist, laboratory procedures, and dental radiology.

Dental Hygiene—an associate degree program, offered in cooperation with Essex County College, in which students are trained to clean teeth, chart disease conditions, and perform other patient services under the dentists' supervision.

Emergency Medical Technology—a one-year program offered jointly with Essex County College, which offers training in emergency care for patients before and during transport to a health

care facility.

Medical Technology—a 12-month clinical program which serves as a segment of the total four year educational program for students pursuing a baccalaureate degree at accredited institutions. This laboratory experience provides practical exposure to laboratory testing such as hematology, urinalysis, and microbiology.

Operating Room Technology—a two-semester program which trains students to assist in surgery with tasks such as prepping patients and sterilizing equipment.

Physicians' Assistants—a baccalaureate program offered in conjunction with Livingston College of Rutgers University, which trains students to assume routine physical examinations and diagnostic procedures in homes, hospitals, and private offices.

Radiologic Technology—a two-year program covering all aspects of diagnosis by x-ray.

Respiratory Therapy—a one-year program which centers on methods of treatment of respiratory problems employing oxygen and other medical gases.

In addition, the school offers several programs which are aimed at augmenting and upgrading the skill of practicing allied health professionals:

Dietetic Internship—an intensive, one-year program, in which graduate dietitians gain practical experience in nutritional assessment and counseling.

Emergency and Critical Care Nursing—a four-week course for nurses already working in emergency, cardiac, and intensive care units, designed to update their knowledge of techniques for care of the acutely traumatized patient.

Nurse Midwifery—a flexible, 12- to 15-month program, for nurses with experience in obstetrics, which trains them to offer the primary care to mothers and newborn, before, during and after birth.

The CMDNJ-School of Allied Health Professions was established as a formal institution of the College in 1976. It originally consisted of several programs which had developed and operated independently at various components of CMDNJ. Since its unification under Dean John P. Martin, Ph.D., the school has attempted to create a consistent and rational network of allied health education statewide.

The development of new technology frequently creates the need for a new type of personnel. One example is a program planned by the school for medical laboratory technicians. Automation

of the medical laboratory has made it possible for many tasks to be performed by technicians with less training and academic preparation than medical technologists. A two-year program, planned in conjunction with Essex County College would produce laboratory technicians who would free the technologist for more sophisticated procedures.

The school's planning also considers the specific needs of the State. It seeks out areas in which New Jersey has identified a lack of adequate programs in a needed specialty. Recognizing that the State has no programs for those seeking advanced degrees in the clinical aspects of sciences such as laboratory biochemistry and physiology, the school has begun preliminary planning of programs which would stress the diagnostic aspects of those fields.

Working in cooperation with the CMDNJ-New Jersey School of Osteopathic Medicine, the school of allied health also plans to take an active role in the development of additional allied health programs in South Jersey, a part of the state that has been traditionally underserved in, health care, lacking adequate professionals at all levels. The two CMDNJ schools will work with community hospitals to expand existing programs and develop new ones.

The CMDNJ-School of Allied Health Professions provides the means for undergraduate institutions to "tap into" CMDNJ's resources of professional expertise and clinical facilities. In several of the existing programs students take their pre-professional classes at the affiliate college, and get practical training under health care professionals in the College's hospitals, clinics and laboratories.

As the State's primary provider of health education, CMDNJ has a responsibility to provide leadership and direction in the formation of a strong, consistent statewide network of training programs for health manpower.

By the end of the decade, a dozen or more allied health professionals may be required to support every physician in practice. To keep pace with new technology and increased demands for service, allied health professions must be educated to assume these vital roles in fulfilling the needs and expectations of our citizens for quality health care. We believe the educational environment of CMDNJ is conducive to development of the team approach under physician and dentist leadership and direction.

Report from the Foundation

Daniel J. O'Regan, M.D.
Medical Director

The New Jersey Professional Standards Review Council became "official" on September 19, 1978, on notification by the Department of Health, Education, and Welfare. NJFHCE was designated as the administrative arm of the Council. This is a goal which we had in mind since our early days as the Statewide PSRO Support Center. Arthur Bernstein, M.D., is President of the Council, and James Rogers, M.D., is Vice-President. The Council is in the process of developing its operating procedures.

The budget for PSROs for this fiscal year will be less than requested by HEW. As a consequence, there will be some revisions to the PSRO review process. The practice of utilization review of all Federal patients (Medicare, Medicaid, and Maternal and Child Health) will be revised. Review will become "focused," or "targeted" more quickly than had been anticipated. PSROs in the northeast will need to identify the socioeconomic and other reasons for utilization figures (expressed in days of care per thousand, and so on) which are substantially above national averages. One reason which we all recognize is the lack of available long-term care facilities. PSRO analyses of such factors should, in time, help to reduce such problems. The interaction of Health Systems Agencies (HSAs) and the PSROs should, if developed properly, help to alleviate those problems of the crowded inner cities which PSRO utilization patterns reflect.

Not all utilization problems can be blamed on lack of alternate beds, of course. PSRO decisions will also have an effect on patterns of practice by physicians and other providers. Some of these decisions will result in reconsiderations and appeals. The appeals procedure will involve the State PSR Council, and will doubtless make for some lively meetings.

Our IPA/HMO Consortium is moving along, with an expression of interest by private industry. NJFHCE's Newsletter will reappear this Fall (like *Life* magazine), and will have more information on the prepaid care field.

Ownership Statement

STATEMENT OF OWNERSHIP, MANAGEMENT AND CIRCULATION

(Required by 39 U.S.C. 3685)

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7. Owner (If owned by a corporation, its name and address must be stated and also immediately thereunder the names and addresses of stockholders owning or holding one percent or more of total amount of stock. If not owned by a corporation, the names and addresses of the individual owners must be given. If owned by a partnership or other unincorporated firm, its name and address, as well as that of each individual, must be given.): The Medical Society of New Jersey, 315 West State St., Trenton, New Jersey 08618 (a non-profit corporation of New Jersey).
8. Known bondholders, mortgages, and other security holders owning or holding one percent or more of total amount of bonds, mortgages or other securities: none (a non-profit corporation of New Jersey).
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11. I certify that the statements made by me above are correct and complete. (Signed)

Robert H. Lambert,
Dir. of Fin. & Adm. Serv.

12. For completion by publishers mailing at the regular rates (Section 132.121, Postal Service Manual). 39 U. S. C. 3626 provides in pertinent part: "No person who would have been entitled to mail matter under former section 4359 of this title shall mail such matter at the rates provided under this subsection unless he files annually with the Postal Service a written request for permission to mail matter at such rates." In accordance with the provisions of this statute, I hereby request permission to mail the publication named in Item 1 at the proposed postage rate presently authorized by 39 U. S. C. 3626. (Signed)

Robert H. Lambert,
Director of Finance and Administrative Services

Physicians Seeking Location in New Jersey

The following physicians have written to the Executive Office of MSNJ seeking information on possible opportunities for practice in New Jersey. The information listed below has been supplied by the physician. If you are interested in any further information concerning these physicians, we suggest you make inquiries directly to them.

CARDIOLOGY—Zouheir H. Elias, M.D., 4014 West 13 Mile Road, Apt. 11, Royal Oak, Michigan 48072. French Faculty (Lebanon) 1974. Subspecialty, internal medicine. Board certified (IM). Group, partnership. Available July 1979.

Dhirendra Mohan, M.D., 757 Main Street, Apt. 30, South Portland, ME 04106. King George (India) 1967. Subspecialty, internal medicine. Board certified (IM). Group or partnership. Available July 1979.

Micha Oren, M.D., Beth Israel Hospital/Harvard Medical School, Division of Cardiology, 330 Brookline Ave., Boston, MA 02213. Tel Aviv (Israel) 1972. Subspecialty, internal medicine. Board certified (IM). Group, partnership, solo, hospital-based. Available July 1979.

CARDIOVASCULAR DISEASES—Michael M. Neumann, M.D., 5415 North Sheridan Road, Chicago, IL 60640. Dusseldorf (Germany) 1971. Subspecialty, internal medicine. Board certified (IM). Group or institution. Available.

DERMATOLOGY—Herbert A. Hochman, M.D., 351 East 84th Street, New York, New York 10028. Tulane 1970. Board certified. Solo, partnership, group (join or purchase). Available.

FAMILY PRACTICE—Scott D. Kirsch, M.D., 19250-7 Hamlin Street, Reseda, CA 91335. SUNY (Buffalo) 1971. Board eligible. Partnership, group. Available January 1979.

Mark H. Krotowski, M.D., 7-29 Hegeman Ave., Apt. 3H, Brooklyn, NY 11212. Tel Aviv University 1976. Board eligible. Partnership, group. Available July 1979.

Dein M. Shapiro, M.D., 3400 Eastern Boulevard, Apt. C-9, York, PA 17402. Georgetown 1976. Single or multi-specialty group. Available.

GASTROENTEROLOGY—Ronald Roth, M.D., P.O. Box 8624, Academy Station, New Scotland Avenue, Albany, NY 12208. Albany Medical College 1974. Subspecialty, internal medicine. Board eligible (IM). Group, partnership, solo. Available July 1979.

David I. Reissman, M.D., 1763 Rolling Lane, Cherry Hill 08003. Albert Einstein 1974. Subspecialty, internal medicine. Board certified (IM). Group or partnership. Available July 1979.

John F. Schultheiss, M.D., Box 6, Second General Hospital, Landstuhl, West Germany. Wisconsin 1970. Subspecialty, internal medicine. Board certified (IM). Group, partnership, or solo. Available October 1979.

GENERAL PRACTICE—Joong Wan Kim, M.D., 220 Bolling Drive, Goldsboro, NC 27530. Busan Medical School (Korea) 1961. Subspecialty, dermatology. Board eligible (family practice). Solo, group. Available February 1979.

Jaw Yan Wang, M.D., 630 West Washington Street, Suffolk, VA 23434. Kaohsiung (Taiwan) 1971. Subspecialty, emergency medicine. Any type practice. Available.

Paul L. Maitheny, M.D., 99 Pawnee Rd., Lakewood 08701. Graz (Austria) 1951. Board eligible (psychiatry). Group. Available.

Jack A. Devor, M.D., 828 Cape View Drive, Fort Myers, Florida 33907. Hahnemann 1966. College or university health service. Available.

GYNECOLOGY—Charles I. Ware, M.D., 3325 Bayshore Boulevard, Apt. B-37, Tampa, FL 33609. University of Maryland 1948. Subspecialty, emergency medicine. Board eligible, obstetrics and gynecology. Group, partnership, emergency room. Available January 1979.

HEMATOLOGY—Mohan Singh Khurana, M.D., 6732 North Kendall Drive, Apt. C-110, Miami, FL 33156. All-India Institute (New Delhi) 1973. Subspecialty, internal medicine. Board certified (IM). Board eligible. Solo, group. Available July 1979.

INTERNAL MEDICINE—Bhattarahally Y. Linganna, M.D., 742 South Cedarhill Drive, Allentown, PA 18103. Mysore (India) 1964. Subspecialty, family practice. Solo, group, emergency room. Available July 1979.

Edward B. Laub, M.D., 25-C Durham Drive, Williamsville, New York 14221. CMDNJ 1976. Group, solo. Available July 1979.

Karkada Jayarama Upadhyaya, M.D., 18-A 250 Ann Street, Easton, PA 18042. Bangalore (India) 1973. Subspecialty, emergency medicine. Group, partnership, emergency room. Available July 1979.

Leonard I. Raifman, M.D., 3333 Henry Hudson Parkway, Apt. 2-P, Riverdale, NY 10463. Guadalajara 1972. Subspecialty, cardiovascular diseases. Board eligible. Group, partnership. Available.

Hasmukh Jariwala, M.D., 222 Westfield Avenue, Roselle Park 07204. S.S. Medical College (India) 1971. Board eligible. Group, partnership, solo, emergency room. Available.

Tsuo-pin Lin, M.D., 1945 Corlies Avenue, Neptune 07753. Kaohsiung (Taiwan) 1971. Solo, partnership, group. Available July 1979.

Jeffrey D. Stahl, M.D., 2122 Cottingham Drive, Lyndhurst, Ohio 44124. Columbia 1974. Subspecialty, gastroenterology. Board eligible. Partnership, group, solo. Available July 1979.

William L. Liao, M.D., 1945 Corlies Avenue, Neptune 07753. University of Philippines 1972. Board eligible. Group, partnership. Available July 1979.

Maung Kyaw Aung, M.D., 5324 18th Avenue, Brooklyn, New York 11204. Institute of Medicine, Burma. Subspecialty, hematology/oncology. Board certified.

Group, solo, hospital-based. Available July 1979.

Jeffrey S. Garbis, M.D., 1425 John Street, Baltimore, Maryland 21217. Guadalajara. Group, partnership, specialty, multi-specialty. Available July 1979.

Harshad R. Mehta, M.D., 1007 Elkin Residence, 5501 North 11th Street, Philadelphia, PA 19141. T.N.M. College (India). Subspecialty, cardiology. Board certified. Group, partnership, solo, institutional. Available July 1979.

Jon David Green, M.D., 509 Fairview Avenue, Orange 07050 (Apt. C-1). CMDNJ 1974. Subspecialty, gastroenterology. Board certified. Solo, partnership, group. Available July 1979.

Richard M. Nisman, M.D., 550 Rossmore Road, Richmond, VA 23225. Medical College of Virginia. Subspecialty, gastroenterology. Board certified. Group, partnership, solo. Available January 1979.

NEOPLASTIC DISEASES—Stanley Ostrow, M.D., 9 Wythwood Court, Baltimore, MD 21209. Downstate 1974. Subspecialty, internal medicine, oncology. Board eligible, oncology. Group or partnership. Available January 1979.

NEUROLOGY—Bharat M. Tolia, M.D., Westchester Medical Center, Valhalla, New York 10595. M.G.M. Medical College (India) 1970. Any type practice. Available July 1979.

OBSTETRICS/GYNECOLOGY—Antonin Dostal, M.D., 64 Elmwood Avenue, Outremont, P.Q., Canada H2V 2E5. Charles University (Czechoslovakia) 1967. Board eligible. Group, partnership, solo. Available March 1979.

Jeffrey M. Reinkraut, M.D., 40-01 Little Neck Pkwy., Little Neck, NY 11363. Rutgers (CMDNJ) 1975. Board eligible. Group or partnership. Available July 1979.

ONCOLOGY—Jorge G. Frank, M.D., 105 Lamb Street, Travis AFB, CA 94535. Subspecialty, neoplastic diseases. Board certified (IM). Board eligible. Group, partnership. Available June 1979.

OPHTHALMOLOGY—David Sheldon Hyman, M.D., 113 Cheltenham Parkway, Cherry Hill 08034. Med. College of Virginia 1975. Group, partnership, solo. Available July 1979.

Steven Bert Siepser, M.D., 24-203 Delaire Landing, Philadelphia, PA 19114. Downstate 1974. Group, partnership, solo. Available July 1979.

Murray H. Rothman, M.D., 67-15 102nd Street, Apt. 75, Forest Hills, NY 11375. Albert Einstein 1974. Board eligible. Group, partnership, solo, research. Available August 1979.

Glenn S. Shear, M.D., Hollandale Apts. #7-B, Clifton Park, NY 12065. Albany Medical College 1975. Group or partnership. Available July 1979.

Pradyumna C. Butala, M.D., 2520 S. King Drive, Apt. 505, Chicago, Illinois 60616. Baroda (India) 1968. Board eligible. Partnership, associate (full time). Available January 1979.

ORTHOPEDICS—Michael Glen Dolin, M.D., 100 Avenue P, Brooklyn, New York 11204. NYU 1970. Board eligible. Any type practice. Available.

OTORHINOLARYNGOLOGY—Naresh C. Goel, M.D., 1996A Village Green South, Providence, RI 02915. All-India Institute (India) 1973. Board eligible. Group, partnership, solo. Available December 1978.

PATHOLOGY—Kirit V. Solanki, M.D., 3635 West College Ave., Apt. 32, Milwaukee, WI 53221. B.J. Medical College (India) 1968. Board certified. Any type practice. Available.

PEDIATRICS—Abraham Nussbaum, M.D., Alpine Village, Apt. 2903, East Greenbush, NY 12061. Albany 1976. Board eligible. Group, partnership, solo. Available July 1979.

Vasanth K. Nalam, M.D., 822 Lincoln Road, Apt. 201, Bellevue, NE 68005. Andhra (India) 1969. Board certified. Group, partnership, institution. Available.

Kamran Tebbi, M.D., 1510 S. Belvoir Boulevard, South Euclid, Ohio 44121. Tehran (Iran) 1967. Subspecialty, hematology. Board certified. Group, partnership, solo, research, academic. Available.

Dolores Protagoras, M.D., 590 Fort Washington Avenue, New York, NY 10033. Wroclaw (Poland) 1965. Board certified. Group, research. Available.

Narendra V. Ambani, M.D., 1945 Corlies Avenue, Neptune 07753. Baroda (India) 1973. Board eligible. Solo, partnership, or group. Available July 1979.

PSYCHIATRY—Vineet P. Kulkarni, M.D., 809 S. Marshfield, Apt. 215, Chicago, IL 60612. Topiwala (India) 1972. Board eligible. Group, partnership. Available.

PULMONARY DISEASES—Mitchell L. Petusevsky, M.D., 5 Cragmore Road, Newton Highlands, Massachusetts 02161. NYU 1975. Board eligible (IM). Group or hospital-based. Available July 1979.

Gautam Desai, M.D., 74-38 43rd Avenue, Elmhurst, NY 11373. Baroda (India) 1970. Subspecialty, internal medicine. Board certified (IM). Board eligible. Group, solo. Available.

RHEUMATOLOGY—Richard K. Mastrole, M.D., 250 Cedar Ridge Drive, Apt. 509, Monroeville, PA 15146. University of Bologna (Italy) 1973. Subspecialty, internal

medicine. Board eligible (IM). Group or partnership. Available July 1979.

SURGERY, CARDIOVASCULAR—Stewart Fox, M.D., Milton S. Hershey Medical Center, Hershey, PA 17033. Medical College of Virginia 1972. Subspecialty, thoracic surgery. Board eligible (general surgery). Group, partnership. Available August 1979.

Naweed Kamran Majid, M.D., Box 85, USAF Hospital, USAF APO New York 09220. King Edward (Pakistan) 1967. Subspecialty, thoracic surgery. Board certified (general surgery). Board eligible. Group, partnership. Available August 1980.

SURGERY, GENERAL—Kadankavil H. Joseph, M.D., 4410 Oglethorpe Street, Apt. #504, Hyattsville, MD 20781. Trivandrum (India) 1970. Subspecialty, abdominal surgery. Board eligible. Group, partnership, research. Available.

Jose P. Arias, M.D., 42-55 Colden Street, Apt. 12-B, Flushing, NY 11355. Univ. of Buenos Aires (Argentina) 1968. Board eligible. Group, partnership, solo. Available December 1978.

Larry Alan Scher, M.D., 44 Lindsley Place, Irvington 07111. Med. College of Wisconsin 1973. Board eligible. Group, partnership. Available July 1979.

Marc David Rudich, M.D., Quarters 131-FE, Warren AFB, WY 82001. Albany Medical College 1971. Subspecialty, cardiovascular surgery. Board certified. Group, partnership, solo, institutional. Available June 1979.

Marc Howard Gertner, M.D., 2201 Pennsylvania Avenue, Apt. 407, Philadelphia, PA 19130. Ohio State 1973. Group, partnership. Available July 1979.

Virgilio S. Ipapo, M.D., 5 Bloomingdale Drive, Apt. 103, South Somerville 08876. Santo Tomas (Philippines) 1971. Board eligible. Group, partnership, institutional. Available June 1979.

Marcel Gardere, M.D., 12 Whitehall Avenue, Edison 08817. Faculte de Med., Haiti 1957. Subspecialty, general practice. Board eligible. Solo, partnership, group, emergency room. Available July 1979.

Rodolfo M. De Ocera, M.D., St. Mary Medical Building, Suite 111, Newtown, Langhorne, PA 19047. Far Eastern University (Philippines) 1961. Subspecialty, general practice. Board eligible. Solo, partnership, group. Available February 1979.

Glenn Pasternack, M.D., 7660 Phoenix Drive, Apt. 1559, Houston, Texas 77030

SUNY—Downstate 1974. Subspecialty, vascular surgery. Board eligible. Group or partnership. Available July 1979.

Charles P. Clericuzio, M.D., 13030 Trail Hollow, Houston, Texas 77079. Wisconsin 1971. Subspecialty, colonoscopy. Board certified. Group, hospital-based, or academic. Available.

Hank S. Lee, M.D., Route 4, Haleyville, Alabama 35565. Catholic Medical College, 1966. Board certified. Solo or partnership. Available.

Ivan A. Shulman, M.D., 785 Burnett Avenue, Apt. 7, San Francisco, CA 94131. Pittsburgh 1972. Board eligible. Group or partnership. Available July 1979.

P. Thaker, M.D., 5 Centennial Drive, Norwood, MA 02062. Baroda (India). Board eligible. Any type practice. Available.

SURGERY, ORTHOPEDIC—Ralph E. Sweeney, Jr., M.D., 9540 Indian Meadows, St. Louis, MO 63132. Georgetown 1973. Any type practice. Available August 1979. Ronald Scheinzeit, M.D., 3432 Alpine Court, Lexington, Kentucky 40502. Albany 1974. Board eligible. Group, association, partnership. Available July 1979.

SURGERY, THORACIC—James R. K. Condon, M.D., 498 Turner Loop, Fort Campbell, KY 42223. Albany 1968. Subspecialty, cardiovascular surgery. Board certified (general surgery). Board eligible. Group, partnership, research. Available July 1979.

SURGERY, UROLOGICAL—Stephen J. Culver, M.D., 2018 La Grange Road, Dayton, OH 45431. University of Cincinnati 1972. Board eligible. Group, partnership, solo. Available July 1979.

Steven H. Paletsky, M.D., 126 C Remington Avenue, Syracuse, NY 13210. Medical University of SC 1973. Group or partnership. Available January 1979.

John A. Fracchia, M.D., 435 East 70th Street, New York, NY 10021. CMDNJ 1973. Group, partnership, solo. Available January 1979.

UROLOGY—Hassan Ismail Alsheik, M.D., 2101 South Oak Park Avenue, Berwyn, Illinois 60402. Damascus (Syria) 1972. Group or solo. Available July 1979.

Wen-I Lin, M.D., 5917 Culzean Drive, Apt. 505, Dayton, Ohio. Kaohsiung (Taiwan) 1968. Group or partnership. Available July 1979.

213th Annual Meeting

May 12-15, 1979

Atlantic City

LETTERS TO THE JOURNAL

Support for CME Concept

September 7, 1978

Dear Editor:

I write to express my strong support for your editorial on continuing medical education in the August issue of *The Journal*. There is clearly an urgent need for more attention to CME in New Jersey, and I like your idea that it be a joint project involving CMDNJ, the Academy of Medicine, the Medical Society, the State Board of Medical Examiners, the State Departments of Health and Higher Education, and so on.

I particularly like your insistence that CME is more than just taking a group of approved courses for credit. It is high time we realized that doctors learn in many ways, and frequently they learn best in ways not designed by professional educators. I have long been convinced that many doctors learn more from chatting with colleagues in the hospital coffee shop or dining room than they do in a classroom. Anyone genuinely concerned with what doctors know and how they apply it must take this sort of learning into account.

My impressions in this regard really should be checked out by scientific measurement. There is remarkably little known about how doctors keep up to date, and there is urgent need for research in this area. There is also need for research in how doctors learn and retain what they have learned. I would see research along these lines as a major component of your proposed Institute.

I guess the only place I would disagree is with your feeling that costs should be borne chiefly by government and foundations. I suspect this is unrealistic at least as long as medicine continues to be

the most remunerative profession in the country. Politicians are inevitably going to resist putting taxpayers' money into teaching doctors how to make even more money than they now do. It is surely appropriate for the research component mentioned above to be supported by government and foundations, but I suspect that for some time to come the major support of the educational program will have to come from fees paid by participants.

(signed) Richard J. Cross, M.D.
Chairman, Department of Community Medicine, Rutgers Medical School

Public Accountability

September 8, 1978

Dear Dr. Somers:

I enjoyed reading the published version of your 9 November 1977 address to the New Jersey Society of Internal Medicine and the New Jersey Chapter of the American College of Physicians, as much as I enjoyed hearing you in person at Atlantic City last spring.

When discussing public accountability and quality protection in terms of the health fields, all of the remarks appear to be directed toward the medical profession, the Joint Commission, and other traditional areas.

There is no mention made of osteopathy and chiropractic. There is no mention made of meddlesome legislatures, which mandate that physicians shall not withhold useless drugs such as laetrile.

It is my opinion that while some osteopaths practice excellent "conventional medicine" there is a much lower degree of public accountability and quality protection afforded to their patients by the various organizations, and there is virtually none afforded to the patients of chiropractors. Nevertheless, they are fighting to expand their recognition, and for access to third party payment, workmen's compensation coverage and otherwise to become primary providers of health care. Podiatrists are fighting to perform radical operations which orthopedic surgeons feel are still experimental and would, in general, not subject their patients to. Are you at all concerned about the growing number of sources of health services which are not accountable to the forces which identify in your presentation?

(signed) Robert A. Goldstone, M.D.

September 15, 1978

Dear Dr. Goldstone:

Thank you for your letter of September 8 and generous comments about my article.

I think you are quite right: a disproportionate amount of criticism is directed to the medical profession. However, this is the price that the profession pays for its leadership role. It receives the lion's share of both praise and criticism.

Needless to say, it is my conviction that the concept of "public accountability" applies to all segments of the health professions.

Best wishes!

(signed) Anne R. Somers
Professor, Department of Community Medicine, Rutgers Medical School

PERSONAL ITEM

Albert L. Rosenthal, M.D. Art Collector and Contributor

Albert L. Rosenthal, a practicing dermatologist in Trenton and staff member of the Mercer and Helene Fuld Medical Centers and of the Trenton Psychiatric Hospital, and Assistant Professor of Dermatology at Philadelphia's Hahnemann Medical School, is vice-president for art at the New Jersey State Museum in Trenton. The Mochican sculpture portrait featured on the cover of this issue is from Dr. and Mrs. Rosenthal's personal collection.

Al and Carol Rosenthal are active art collectors, specializing in German expressionism, mostly from the pre-World War I era, and pre-Columbian art. Their

collection includes works by Edward Munch, Emil Nolde, Kandinsky, Klimt, Kokoschka, Feininger, Dix, Heckel, and Beckmann.

A graduate of Tufts University and Tufts Medical School, Dr. Rosenthal studied surgery and dermatology at New York University and Massachusetts General Hospital. His interest in archaeology was stimulated by his dentist father, while his avidity for artifacts and fine art developed through self-study, undergraduate courses in art history and extensive travels to Mexico, Peru, Ecuador, Greece, Crete, Israel, and throughout Europe.

Carol Rosenthal has served the New Jersey State Museum as vice-chairman for the Artlease and Sales Gallery from its inception in 1973.

Beyond their services to the museum, the Rosenthals have made substantial gifts of fine art to that state institution, including works by Reginald Marsh, John Sloan, Abraham Walkowitz, B.J.O. Nordfeldt, Jules Pascin, George Grosz, and Werner Drewes. In recognition of the nation's bicentennial celebration, they gave a group of etchings of early Trenton scenes by George Bradshaw.

Al Rosenthal demonstrates that one can be a respected and skilled medical specialist yet maintain a growing interest and knowledge in a field of culture which is both demanding and rewarding. Medicine and art, like music and medicine, enhance an interesting life and this physician makes the most of the couplet.

A. Krosnick, M.D.

CME INFORMATION

Basic Sciences and Clinical Application

The Burlington County Memorial Hospital in Mount Holly has announced the following program in its series on basic sciences and clinical application. Sessions convene Thursdays at 3:30 p.m. on the dates indicated, in the conference center of the hospital. Each lecture meets the criteria for one credit hour in Category I of the AMA Physician's Recognition Award. For information please communicate with Dr. Robert W. Parvin, Director of Medical Education at the hospital, 175 Madison Avenue, Mount Holly 08060.

Nov. 16 Shock and Its Complications
Nov. 30 Potassium Imbalance
Dec. 7 Hyperlipidemia
Dec. 14 "Small" Infections
Dec. 21 Senile Cataract

Sports Medicine Series

The Orthopedic Section, Division of Sports Medicine, New Jersey Medical School, CMDNJ, has announced the following Distinguished Guest Lecturer Series in Sports Medicine. The first program—on football injuries—was held on September 7. Additional scheduling is as follows:

November 16—Medical Aspects of Soccer
December 7—Writing Your Clinical Paper

Lectures will be held at 7 p.m. in Room B-610 of the Medical Science Building, 100 Bergen Street, Newark. Following each presentation there will be a half-hour question and answer period. There is no fee. For information please communicate with Mrs. Anne Stephans at the College—(201) 456-5350.

VA Medical Grand Rounds

The following program has been announced by the Pulmonary Disease Section of the Veterans Administration Hospital in East Orange. Sessions are held on Wednesdays on the dates indicated at 11:30 a.m. in the third floor amphitheatre of the hospital. The first program, "Diagnostic Techniques in Pulmonary Diseases," was held on September 20.

November 29—Pharmacology and Treatment of Bronchial Asthma: Carl B. Sherter, M.D., Yale University School of Medicine

December 20—Tracheobronchial Tree in Relation to Environmental Hazards: Oscar Auerbach, M.D., VA Hospital, East Orange

April 18—Thromboembolic Disease: Sol Sherry, M.D., Temple University School of Medicine

T and A Controversy

On November 29, under the sponsorship of Morristown Memorial Hospital's Departments of Otolaryngology and Pediatrics and Warner-Lambert Pharmaceutical Company, a program entitled "The T & A Controversy" will be presented from 1 to 5 p.m. at the Old Mill Inn in Basking Ridge. Speakers will be Phillip M. Sprinkle, M.D., Professor of Otolaryngology at West Virginia University School of Medicine, giving the otolaryngologist's view, and Jack Paradise, M.D., Associate Professor of Pediatrics at Children's Hospital of Pittsburgh, discussing the pediatrician's viewpoint. There will be a panel discussion headed by Doctors Richard Rapkin, Richard Goldsmith, Howard Farmer, and Myron Shapiro. Registration fee is \$15. Luncheon and dinner will be available at the Old Mill Inn before and after the meeting. Four credits will be awarded in Category I of the AMA Physician's Recognition Award. For further information please communicate with Stephen F. Wang, M.D., chairman, Department of Pediatrics, Morristown Memorial Hospital, 100 Madison Avenue, Morristown 07960—(201) 540-5132.

Conference on Package Inserts

Under the sponsorship of the Food and Drug Administration, a conference will be held at the Shoreham Americana Hotel in Washington, D.C. on December 11 and 12 to consider matters concerning patient-package inserts for a wide range of drugs. Theme of the conference is focused specifically on how to choose contents and methods of presentation for selected prototype drugs. Advice is sought from a variety of perspectives, and input from health professionals, consumers, and others interested is solicited. Registration is free but to facilitate arrangement of workshops pre-registration is urged. Requests for information and registration forms

should be directed to Ms. Ann Myers, HFD-107, Food and Drug Administration, 5600 Fishers Lane, Rockville, MD 20857—(301) 443-6004.

Radiology of Acutely Ill or Injured Patient

A program on radiology of the acutely ill or injured patient is being offered on January 26 and 27 (1979) at Stouffer's Hotel, Houston, Texas, under the auspices of the University of Texas Medical School at Houston, the University of Texas Health Science Center, and the School of Allied Health Sciences Division of Continuing Education. The course meets the criteria for 14 credit hours in Category I of the AMA Physician's Recognition Award. Application has been made for accreditation by the American College of Emergency Physicians and the American Academy of Family Physicians. Tuition is \$150 and request for information and registration should be made to the Division of Continuing Education, The University of Texas Health Science Center at Houston, P.O. Box 20367, Houston, Texas 77025.

ACS National Conference on Urologic Cancer

From April 4 to 6, 1979, the American Cancer Society will sponsor a national conference on urologic cancer to be held at the Hilton Hotel, Los Angeles, California. The purpose of the conference is to improve the care of the urologic cancer patient by bringing the best available information in this field to the attention of the general medical community. Emphasis will be in specific areas where advances in understanding and management are occurring, and the presentation will be multidisciplinary and objective in orientation. Attendance is open to physicians and medical students. There is no registration fee, but advance registration is requested. Fifteen and one-half hours will be given in Category I of the AMA Physician's Recognition Award. For further information, please communicate with the Urologic Cancer Conference, American Cancer Society, 777 Third Avenue, New York, NY 10017—(212) 371-2900.

Retraining Program for Inactive Physicians

The 1979 Spring and Fall retraining programs for inactive physicians have been announced by the Medical College of Pennsylvania. The first session is held from April 23 to June 15 and the deadline for applications is January 1st. Reservations for the Fall program (October 15 to December 8) must be received by July 1st. These are refresher courses in general medicine for physicians who wish to re-enter clinical medicine. Included is a review of physical diagnostic skills, experience in clinical rotations, a lecture series on general medicine, pathophysiology, diagnosis, and patient management. This series has retrained more than 100 physicians, nearly all of whom have returned to active practice. For information and application please write to Mrs. C. M. Trulear, Program Administrator, Retraining Program for Inactive Physicians, Medical College of Pennsylvania, 3300 Henry Avenue, Philadelphia 19129—(215) 842-7118.

CME Home Study Program

A self-assessment and home study program for physicians in primary care, under the caption of "Practice Related Educational Program (PREP)," is being offered through the Academy of Medicine of New Jersey. Designed by the College of Physicians of Philadelphia and endorsed by the Pennsylvania Medical Society, the Association for Hospital Medical Education, and the Medical Society of New Jersey, this activity, when completed as designed, meets the criteria for twenty credit hours per learning cycle in Category I of the Physician's Recognition Award of the AMA. Complete confidentiality is assured. One learning cycle consists of a practice profile as determined from completed practice survey forms for 100 patients, self-assessment of the selected learning area and receipt of a corrected answer sheet, selection of self-learning materials, post-learning self-assessment and receipt of corrected answers. For information please communicate with the Academy of Medicine, 2424 Morris Avenue, Union, New Jersey 07083—(201) 687-8780.

CME CALENDAR

This listing is compiled through the cooperation of the Committee on Medical Education of the Medical Society of New Jersey, the Academy of Medicine of New Jersey, the New Jersey Chapter of the American Academy of Family Physicians, and the Office of Continuing Medical Education of the College of Medicine and Dentistry of New Jersey. For information on accreditation, please contact the sponsoring organization(s), indicated by italics—last line of each item.

December

- 1 Proper Use of Antibiotics**
8:30-9:30 a.m.—United Hospitals of Newark
(*United Hospitals of Newark and AMNJ*)
- 1 Diagnostic and Therapeutic Problems in**
- 8 Orthopedics**
22 7:30-9 a.m.—Alexian Brothers Hospital, Elizabeth
(*Alexian Brothers Hospital*)
- 1 Advances in Pediatrics**
8 9:30-10:30 a.m.—NJ Medical School,
15 Newark
22 (*CMDNJ and AMNJ*)
- 1 Psychiatric Lecture Series**
1:30-5 p.m.—Trenton Psychiatric Hospital
(*Trenton Psychiatric Hospital and AMNJ*)
- 2 27th Annual Clinical Meeting**
9 a.m.-4:15 p.m.—NJ Medical School, Newark
(*NJ Chapter, American College of Surgeons and AMNJ*)
- 4 Neuroscience Conferences**
11 11:30 a.m.-12:30 p.m.—Bergen Pines
18 County Hospital, Paramus
(*Bergen Pines County Hospital and AMNJ*)
- 4 Psychiatric Lecture Series**
8-10 p.m.—192 Chittenden Rd., Clifton
(*Essex Psychiatric Seminar and AMNJ*)
- 4 Lecture Series in Surgery**
11 4:30-5:30 p.m.—NJ Medical School,
18 Newark
25 (*CMDNJ and AMNJ*)
- 5 Why Treat Diabetes?**
- 12 Secondary Causes of Hypertension**
8-9 a.m.—Greater Paterson General Hospital, Wayne
(*Greater Paterson General Hospital and AMNJ*)
- 5 Gastrointestinal Bleeding**
8-9 p.m.—Burdette Tomlin Memorial Hospital, Cape May Courthouse
(*Burdette Tomlin Memorial Hospital and AMNJ*)
- 5 Colorectal Carcinoma**
5-6 p.m.—Rutgers Medical School, Piscataway
(*CMDNJ and AMNJ*)

- 5 Medical Emergency Care**
- 12 Colitis**
- 19 Medical Genetics**
11 a.m.-12 noon—Greystone Park Psychiatric Hospital
(*Greystone Park Psychiatric Hospital and AMNJ*)
- 5 Seminar on Law and Psychiatry**
12 3:30-5:30 p.m.—Rutgers Law School,
19 Newark
26 (*Rutgers University Law School and AMNJ*)
- 5 Fevers of Unknown Origin**
9-11 p.m.—Saddle Brook Hospital
(*Saddle Brook Hospital and AMNJ*)
- 6 Regional Conference—Ambulatory Pediatric Association**
8:30 a.m.-4 p.m.—Newark Beth Israel Medical Center, Newark
(*Ambulatory Pediatric Association and Newark Beth Israel Medical Center*)
- 6 Genetics**
- 13 Septic Shock**
1-3 p.m.—Christ Hospital, Jersey City
(*Christ Hospital and AMNJ*)
- 6 Lectures in Obstetrics and Gynecology**
8-10 p.m.—Location varies
(*CMDNJ and AMNJ*)
- 6 Sepsis and Endotoxic Shock**
10:30 a.m.-12 noon—St. Mary's Hospital, Passaic
(*St. Mary's Hospital and AMNJ*)
- 6 Psychiatric Emergencies**
- 20 Antianxiety and Antidepressants**
1-3 p.m.—Ancora Psychiatric Hospital, Hammonton
(*Ancora Psychiatric Hospital and AMNJ*)
- 6 Systemic Mycoses**
- 13 Nutritional Issues in Clinical Medicine**
- 20 Endocrine Aspects of Aging**
9-11 a.m.—Middlesex General Hospital, New Brunswick
(*Middlesex General Hospital, AMNJ and AAFP*)
- 6 Medical Grand Rounds**
11:30 a.m.—Rotates between Newark Beth Israel Medical Center, Martland, and East Orange VA Hospitals
(*AMNJ Endocrinology Section*)
- 6 Endocrinology—Dinner Meeting**
6:30-9:30 p.m.—Holiday Inn, East Orange
(*AMNJ Endocrinology Section*)
- 6 Advances in Medicine**
13 9:30-11 a.m.—Bergen Pines County
20 Hospital, Paramus
27 (*Bergen Pines County Hospital and AMNJ*)
- 6 Continuing Education in Psychiatry**
13 1-3 p.m.—Bergen Pines County
20 Hospital, Paramus
27 Paramus
(*Bergen Pines Hospital and AMNJ*)

- 6 Individualization of Drug Therapy**
- 13 Dizziness**
- 20 Chemistry Laboratory and Liver Disease**
9-11 a.m.—Riverview Hospital, Red Bank
(*Riverview Hospital and AMNJ*)
- 6 The Anxiety Syndrome**
- 13 Antibiotic Rx**
- 20 Common Hematologic Problems**
11:30 a.m.-1:30 p.m.—Rahway Hospital
(*Rahway Hospital and AAFP*)
- 6 Grand Rounds and Case Presentations**
13 2-4 p.m.—Rotates between Martland,
20 Newark Beth Israel, St. Michael's, St. Joseph's Hospital, and Jersey City Medical Center
(*CMDNJ and AMNJ*)
- 6 Clinical Pathology Grand Rounds**
13 12 noon-1 p.m.—New Jersey Medical
20 School, Newark
27 (*CMDNJ and AMNJ*)
- 7 Psychiatric Lecture Series**
14 11 a.m.-12 noon—Greystone Psychiatric
21 Hospital
(*Greystone Psychiatric Hospital and AMNJ*)
- 7 Neurosurgical Case Presentations**
14 4:5-5:30 p.m.—NJ Medical School,
21 Newark
(*CMDNJ and AMNJ*)
- 7 Writing Your Clinical Paper**
7-8:30 p.m.—NJ Medical School, Newark
(*CMDNJ and AMNJ*)
- 7 Virology**
14 4-6 p.m.—Institute for Medical Research, Copewood St., Camden
(*Institute for Medical Research and AMNJ*)
- 7 Normal Diet—Food Fads and Vitamins**
- 12 Weight Control, Diet, and Pregnancy**
- 14 Lipid Profile**
11:45 a.m.-12:45 p.m.—John F. Kennedy Medical Center, Edison
(*John F. Kennedy Medical Center*)
- 7 Grand Rounds and Case Presentations**
14 4-5 p.m.—Martland Hospital, Newark
21 (*CMDNJ and AMNJ*)
28
- 7 Psychiatric Ethics**
- 14 Hysterical Dissociation**
12 noon-1 p.m.—Carrier Foundation, Belle Mead
(*The Carrier Foundation*)
- 7 Psychotherapeutic Techniques**
8-10 p.m.—312 Harding Drive, South Orange
(*Group for Advanced Psychiatric Study and AMNJ*)
- 7 Cardiology Conferences**
14 2:15-4:15 p.m.—Deborah Heart and
21 Lung Center, Browns Mills
28 (*Deborah Heart and Lung Center and AMNJ*)

- 11 **Problem Cases in Cancer**
7:45-9 a.m.—Newark Beth Israel Medical Center
(*Newark Beth Israel Medical Center and AMNJ*)
- 12 **Stress Testing**
8-9 a.m.—Garden State Community Hospital, Marlton
(*Garden State Community Hospital and AMNJ*)
- 12 **Clinical Pharmacology**
12-3 p.m.—Ancora Psychiatric Hospital, Hammonton
(*Ancora Psychiatric Hospital and AMNJ*)
- 12 **Pulmonary Disease—Proper Use of Blood Gases**
8:30-9:30 p.m.—Omar's Restaurant, Saddle River Road, Fair Lawn
(*Fair Lawn Memorial Hospital and AMNJ*)
- 13 **Endocrine Conferences**
20 3:30-5 p.m.—Rotates between Newark
27 Beth Israel Medical Center, Martland, and East Orange VA Hospitals
(*AMNJ*)
- 13 **Depression**
9:30-11:30 a.m.—Dover General Hospital
(*Riverside, Dover General, St. Clare's Hospitals and AMNJ*)
- 13 **The New Immigrant in America**
1:30-3 p.m.—NJ Medical School, Newark
(*CMDNJ and AMNJ*)
- 13 **Uveitis Problems**
7:15-9:30 p.m.—United Hospitals Medical Center, Newark
(*Associated Eye Residences of NJ and AMNJ*)
- 14 **The Alcoholic Patient**
5-6:30 p.m.—Somerset Hospital, Somerville
(*Somerset Hospital and AMNJ*)
- 14 **Case Presentations and Guest Speakers**
7:30-9:30 p.m.—Location to be announced
(*New Jersey Institute of Ultrasound in Medicine and AMNJ*)
- 15 **Management of the Juvenile Diabetic**
8:15-10:30 a.m.—Overlook Hospital, Summit
(*Overlook Hospital and AMNJ*)
- 19 **Cardiopulmonary Complications of the Surgical Patient**
8-10 p.m.—The Englewood Club, Englewood
(*Englewood Surgical Society and AMNJ*)
- 19 **Adrenal Diseases**
11:30 a.m.-12:30 p.m.—St. Mary's Hospital, Orange
(*St. Mary's Hospital and AMNJ*)
- 20 **Diagnosis and Management of Shock**
1-2 p.m.—Trenton Psychiatric Hospital
(*Trenton Psychiatric Hospital and AMNJ*)
- 20 **Tracheobronchial Tree and Environmental Hazards**
11:30 a.m.-1 p.m.—VA Hospital, East Orange
(*VA Hospital and AMNJ*)
- 20 **Psychosomatic Aspects of Anxiety**
1:30-3 p.m.—VA Hospital, Lyons
(*VA Hospital and AMNJ*)
- 27 **Neuropathology Conferences**
8-9:15 a.m.—New Jersey Medical School, Newark (*CMDNJ and AMNJ*)
- 27 **Cardiac Grand Rounds**
3-4:30 p.m.—NJ Medical School, Newark
(*American Heart Association, NJ Affiliate and AMNJ*)
- January
- 2 **Seminar on Law and Psychiatry**
9 3:30-5:30 p.m.—Rutgers Law School, Newark
16 (*Rutgers University Law School and AMNJ*)
- 23 **Lectures in Obstetrics and Gynecology**
3 8-10 p.m.—Location Varies
(*CMDNJ and AMNJ*)
- 3 **Endocrinology—Dinner Meeting**
6:30-9:30 p.m.—Holiday Inn, East Orange
(*AMNJ Endocrinology Section*)
- 3 **Medical Grand Rounds**
11:30 a.m.—Rotates between Newark Beth Israel Medical Center, Martland and East Orange VA Hospitals
(*AMNJ*)
- 3 **Seizure Disorders, Diagnosis and Management**
31 **Congenital Diseases**
10:30 a.m.-12 noon—St. Mary's Hospital, Passaic
(*St. Mary's Hospital and AMNJ*)
- 3 **Psychopharmacology Update**
17 **Epilepsy and Convulsive Disorders**
31 **Psychosomatic Medicine**
1-3 p.m.—Ancora Psychiatric Hospital, Hammonton
(*Ancora Psychiatric Hospital and AMNJ*)
- 3 **Immunology: Clinical**
10 **Peripheral Vascular Disorders**
17 **Difficult Biliary Problems**
24 **Granulomatous Bowel Diseases**
31 **Sports Medicine**
1-3 p.m.—Christ Hospital, Jersey City
(*Christ Hospital and AMNJ*)
- 3 **Drugs and Pregnancy**
10 **Adolescent Health Care**
17 **The Addictive Personality: Drug and Alcohol Dependence**
24 **Drug Therapy in Psychiatric Disorders of Older Patients**
31 **Management of Acute and Chronic Alcoholism in Clinical Patients**
9-11 a.m.—Middlesex General Hospital, New Brunswick
(*Middlesex General Hospital, AMNJ and AAFP*)
- 3 **Grand Rounds and Case Presentations**
10 2-4 p.m.—Rotating between Martland, Newark Beth Israel, St. Michael's, St. Joseph's Hospitals, and Jersey City
24 **Medical Center**
(*CMDNJ and AMNJ*)
- 3 **Clinical Pathology Grand Rounds**
10 12 noon-1 p.m.—NJ Medical School, Newark
17 (*CMDNJ and AMNJ*)
- 24 **Advances in Medicine**
3 9:30-11 a.m.—Bergen Pines County Hospital, Paramus
10 (*Bergen Pines County Hospital and AMNJ*)
- 17 **Endocrine Conference**
3 3:30-5 p.m.—Rotates between Newark Beth Israel Medical Center, Martland, and East Orange VA Hospitals
24 (*AMNJ Endocrinology Section*)
- 31 **Clinical Enzymology**
10 **Complications of Diabetes**
17 **The Common Hyperlipoproteinemias**
- 24 **Lower Gastrointestinal Bleeding**
31 **Treatment of Patients with Major Burns**
9-11 a.m.—Riverview Hospital, Red Bank
(*Riverview Hospital and AMNJ*)
- 4 **Arthritides**
9 **Vaginal Bleeding**
11 **Rheumatic Fever**
18 **Surgery and Arthritis**
25 **X-ray of the Spine**
11:45 a.m.-12:45 p.m.—John F. Kennedy Hospital, Edison
(*John F. Kennedy Hospital*)
- 4 **Neurosurgical Case Presentations**
11 4-5:30 p.m.—NJ Medical School, Newark
18 (*CMDNJ and AMNJ*)
- 4 **Virology**
11 4-6 p.m.—Institute for Medical Research, Copewood St., Camden
18 (*Institute for Medical Research and AMNJ*)
- 25 **Psychotherapeutic Techniques**
8-10 p.m.—312 Harding Drive, South Orange
(*Group for Advanced Psychiatric Study and AMNJ*)
- 4 **Psychiatric Lecture Series**
11 11 a.m.-12 noon—Greystone Park
18 Psychiatric Hospital
25 (*Greystone Park Psychiatric Hospital and AMNJ*)
- 4 **Grand Rounds and Case Presentations**
11 4-5 p.m.—Martland Hospital, Newark
18 (*CMDNJ and AMNJ*)
- 25 **Cardiology Conferences**
11 2:15-4:15 p.m.—Deborah Heart and Lung Center, Browns Mills
18 (*Deborah Heart and Lung Center and AMNJ*)
- 25 **Obesity**
8:30-9:30 a.m.—United Hospitals of Newark
(*United Hospitals of Newark and AMNJ*)
- 5 **Diagnostic and Therapeutic Problems in Orthopedics**
12 7:30-9 a.m.—Alexian Brothers Hospital, Elizabeth
26 (*Alexian Brothers Hospital*)
- 5 **Advances in Pediatrics**
12 9:30-10:30 a.m.—NJ Medical School, Newark
19 (*CMDNJ and AMNJ*)
- 26 **Lecture Series in Surgery**
8 4:30-5:30 p.m.—NJ Medical School, Newark
15 (*CMDNJ and AMNJ*)
- 21 **Psychiatric Lecture Series**
28 8-10 p.m.—111 Ridgewood Ave., Glen Ridge
(*Essex Psychiatric Seminar and AMNJ*)
- 8 **Neuroscience Conferences**
15 11:30 a.m.-12:30 p.m.—Bergen Pines County Hospital, Paramus
22 (*Bergen Pines County Hospital and AMNJ*)
- 29 **Bleeding Diseases**
9 **Diagnosis of Anemic Patient**
16 **Management of Hepatitis**
23 11 a.m.-12 noon—Greystone Park Psychiatric Hospital
(*Greystone Park Psychiatric Hospital and AMNJ*)
- 9 **Skin Infections**
8-10 p.m.—Schering Corporation,

	Kenilworth (<i>NJ Dermatological Society and AMNJ</i>)				
9	Lower Limb Grafting Procedures 8-9 a.m.—Greater Paterson General Hospital, Wayne (<i>Greater Paterson General Hospital and AMNJ</i>)	11	Psychogeography 8:30-10:30 p.m.—Hackensack Hospital (<i>Hackensack Hospital and AMNJ</i>)		(<i>Diagnostic Radiology Section for Northern New Jersey and AMNJ</i>)
		11	Case Presentations with Guest Speakers 7:30-9:30 p.m.—Location to be announced (<i>NJ Institute of Ultrasound in Medicine and AMNJ</i>)	18	Management of Breast Cancer 5-6:30 p.m.—Somerset Hospital, Somerville (<i>Somerset Hospital and AMNJ</i>)
10	Nutrition Update 9:30-11:30 a.m.—Dover General Hospital (<i>Riverside, Dover General, St. Clare's Hospitals and AMNJ</i>)	16	Hepatitis 7-8 p.m.—Irvington General Hospital (<i>Irvington General Hospital and AMNJ</i>)	23	Alcoholism 8-9 p.m.—Warren Hospital, Phillipsburg (<i>Warren Hospital and AMNJ</i>)
10	Depression in the Community	16	Seizure Disorders 11:30 a.m.-12:30 p.m.—St. Mary's Hospital, Orange (<i>St. Mary's Hospital and AMNJ</i>)	23	Fundamentals of Hemostasis for Surgeons 8-10 p.m.—The Englewood Club, Englewood (<i>Englewood Surgical Society and AMNJ</i>)
24	Child Psychology 1:30-3 p.m.—NJ Medical School, Newark (<i>CMDNJ and AMNJ</i>)	17	Thanatology 1-2 p.m.—Trenton Psychiatric Hospital (<i>Trenton Psychiatric Hospital and AMNJ</i>)	24	Neuropathology Conferences 8-9:15 a.m.—NJ Medical School, Newark (<i>CMDNJ and AMNJ</i>)
10	Alcoholism 11:30 a.m.-12:30 p.m.—Rahway Hospital (<i>Rahway Hospital and AMNJ</i>)	17	Radiotherapy Section Dinner Meeting 6:30-8:30 p.m.—The Manor, West Orange (<i>AMNJ</i>)	27	NJPA Annual Meeting 9 a.m.-4 p.m.—Buck Hill Inn, Pa. (<i>NJ Psychiatric Association and AMNJ</i>)
10	Cerebral Vascular Disease 1:30-2:30 p.m.—John E. Runnells Hospital, Berkeley Heights (<i>John E. Runnells Hospital and AMNJ</i>)	18	Aneurysms of the Aorta 7:15-10:15 p.m.—Hospital Center at Orange	31	Cardiac Grand Rounds 3-4:30 p.m.—NJ Medical School, Newark (<i>American Heart Association, NJ Affiliate and AMNJ</i>)

Housing Application

213th Annual Meeting

The Medical Society of New Jersey

May 12-15, 1979

	DAILY RATES		
	Single	Twin	Suites
Holiday Inn (MSNJ Headquarters)	\$42	\$46	Rates quoted upon request
	50	54	
	58	62	
Howard Johnson's (Auxiliary Headquarters)	\$42	\$46	Rates quoted upon request
	50	54	
	58	62	

If room is not available at rate requested, next available rate will be assigned

Mail this application directly to the Atlantic City Convention Bureau
16 Central Pier
Atlantic City, N.J. 08401

Please list 1st and 2nd choice; confirmation will come directly from hotel.

1st Choice.....2nd Choice.....

Accommodations desired: ☐ Single ☐ Twin ☐ Suite Parlor & 1 Bedroom
☐ Suite Parlor & 2 Bedrooms

Name.....

Address.....

City..... State..... Zip.....

Phone.....

Will arrive..... Time..... Will depart..... Time.....
DATE DATE

☐ Check if Official Delegate..... County

Dr. Samuel T. Busansky

One of Burlington County's senior members, Samuel T. Busansky, M.D., of Browns Mills, died on August 23. Born in New York City in 1902, Dr. Busansky was graduated from New York University Medical School, class of 1927. He practiced general medicine, with special interest in chest diseases, and had been affiliated with the Burlington County Memorial Hospital in Mount Holly and with the Deborah Hospital in Browns Mills. He had been active in his local community and served as school physician to Pemberton Township, Pemberton Borough, and Wrightstown. Dr. Busansky was a Fellow of the American College of Chest Physicians and a member of the National Tuberculosis Association.

Dr. Ignazio Dell'Aira

Ignazio Dell'Aira, M.D., a member of our Monmouth County component, died in Riverview Hospital, Red Bank, on September 10th. Born in Naro, Italy in 1911, Dr. Dell'Aira earned his medical degree from the University of Palermo in 1937. He practiced briefly in his native land and served in the Italian Army during World War II. In 1947 Dr. Dell'Aira emigrated to the United States and worked as a resident staff member at several hospitals in Westchester County, New York and on Long Island, and at St. Mary's Hospital in Hoboken before coming to Hazlet Township in Monmouth County in 1960 to establish a private practice in general medicine. He was affiliated with Riverview Hospital in Red Bank and Monmouth Medical Center in Long Branch.

Dr. Joseph Lubchak

Word has just been received of the death, on August 19, of Joseph Lubchak, M.D., a member of our Hudson County component. Born in 1904, Dr. Lubchak earned his medical degree in Poland, graduating in 1931. He emigrated to the United States and es-

tablished a practice in anesthesiology in Weehawken. Dr. Lubchak was a member of the American Society of Anesthesiologists and of the New Jersey State Society of Anesthesiologists, and, until his retirement in 1976, was affiliated with Fairmount and St. Francis Hospitals in Jersey City.

Dr. A. Donald McLane

A. Donald McLane, M.D., a member of our Bergen County component, died on August 12 in Delray Beach, Florida, after a long illness. A graduate of Georgetown University Medical School, class of 1930, Dr. McLane had practiced general surgery in Englewood for many years. Illness forced his retirement in the late 1960s and recently he had moved to Florida. He had been on the attending surgical staffs at Englewood and Holy Name Hospitals in Teaneck. He was a Fellow of the American College of Surgeons and of the International College of Surgeons. Dr. McLane was 74 years old at the time of his death.

Dr. Mario L. Pesaresi

Word has been received of the death on July 26 of Mario L. Pesaresi, M.D., a member of our Bergen County component. A native of New Jersey, Dr. Pesaresi was graduated from New York Medical College in 1955 and, following internship at the Hackensack Hospital, took residencies in psychiatry at the Veterans Administration Hospital in Lyons and in child psychiatry at the Mount Sinai Hospital in New York. In 1955 he established a practice in those specialties in Hackensack and became affiliated with the Hackensack Hospital and the Englewood Hospital. Dr. Pesaresi was only 50 years old at the time of his death.

Dr. Robert F. Pierozak

Robert F. Pierozak, M.D., a member of our Union County component, died on September 20, at the untimely age of 53. Dr. Pierozak was graduated from

Georgetown University Medical School, class of 1950, and established a practice in general medicine in Linden, with emphasis on internal medicine. He was a diplomate of the National Board of Medical Examiners, a member of the Academy of Medicine of New Jersey, and of the American Academy of Family Practice. Dr. Pierozak served on the staffs of St. Elizabeth's and Alexian Brothers Hospitals in Elizabeth, and for a two-year term beginning in 1973 served as president of the medical staff at the latter hospital. He attained the rank of major while serving in the United States Army from 1950 to 1955. Dr. Pierozak's hobbies included breeding black angus and whiteface hereford beef cattle on a farm in Ringoes.

Dr. Emanuel M. Satulsky

The 178th President of the Medical Society of New Jersey, Emanuel M. Satulsky, M.D., died on September 10 after a protracted illness. Long active in organized medicine, Dr. Satulsky had been president of his county medical Society (Union), member and chairman of the State Society's Judicial Council, secretary and later chairman of the Section on Dermatology, president of the New Jersey Dermatological Society, member of the Board of Trustees of the Academy of Medicine of New Jersey, and currently was an AMA Delegate, having served several terms as an Alternate Delegate. In addition he held membership on many Society committees and liaison committees dealing with Society business.

Born in 1909 and graduated from the University of Maryland School of Medicine in 1934, Dr. Satulsky took further training at the skin and cancer unit of New York Postgraduate Medical School and was board certified in dermatology and syphilology. He was a Fellow of the American Academy of Dermatology and had been affiliated with Elizabeth General and Alexian Brothers Hospitals in Elizabeth and with the Rahway Hospital. He also was active in civic affairs and during the 1960s was appointed to

the Elizabeth Board of Health and was instrumental in reshaping that city's department of health. During World War II, Dr. Satulsky served for five years in the medical department of the Army of the United States.

Dr. Benjamin N. Schenker

We have just learned of the death on August 26 of Benjamin N. Schenker, M.D., at St. Francis Hospital in Jersey City. Born in Buffalo, New York, Dr. Schenker earned his medical degree from the Eclectic School of Medicine in Cincinnati, Ohio in 1928, and established a practice in general medicine in downtown Jersey City, where he remained for forty years. He was well known in the community for his kindness to indigent patients during the depression years. Dr. Schenker was a member of the New Jersey and National Eclectic Societies, and was active in local religious and fraternal organizations, having served for the past 35 years as president of Congregation Tiforoth Israel. He was president of the medical staff of Greenville Hospital in Jersey City and also was affiliated with Jersey City Medical Center. Dr. Schenker was listed in *Who's Who in Medicine*. He attained the rank of captain in the Army of the United States during World War II. Dr. Schenker was 77 years old at the time of his death.

Dr. Fannie Sender

A member of our Middlesex County component, Fannie Sender, M.D., of Rumson, died on September 13. Born in Russia in 1901, Dr. Sender emigrated to the United States and earned her medical degree from Long Island University College of Medicine in 1929. She practiced general medicine in South River until her retirement in 1971. Dr. Sender had been affiliated with Perth Amboy General Hospital.

Dr. Walter K. Shelley

Walter K. Shelley, M.D., a member of

our Essex County component, died on July 28 in Mountinside Hospital, Glen Ridge, after a long illness. Born in Russia where he earned his medical degree in 1933, Dr. Shelley emigrated to the United States in 1950 and took graduate training at St. Peter's Hospital in New Brunswick. For many years he was on the full-time medical staff at the Essex County Hospital Center in Cedar Grove, retiring in 1977. Dr. Shelley was 69 years old at the time of his death.

Dr. Henry A. Toczek

One of Essex County's senior members, Henry A. Toczek, M.D., died on July 9 in Newark Beth Israel Medical Center of a heart ailment. Born in 1898 in Frankfurt (Germany), Dr. Toczek was graduated from the medical school of the University of Berlin in 1923 and emigrated to the United States in the mid-1930s. He had practiced general medicine in Newark for many years and had been affiliated with Newark Beth Israel, St. James, Newark Lutheran, and Orange Memorial Hospitals.

Dr. Stephen Vaczi

At the grand age of 83, Stephen Vaczi, M.D., a well-known, retired Mercer County practitioner, died in Helene Fuld Medical Center, Trenton, on August 6. Born in Budapest, Hungary, Dr. Vaczi received his medical degree from the University of Budapest Medical College in 1918 and took graduate work in otolaryngology at Columbia Medical Center in New York and at the University of Vienna. He had practiced in Trenton for 50 years before retiring in 1970. Dr. Vaczi had been one of the founders of the now defunct Chambersburg Hospital in Trenton and a member of the clinical staff at the Postgraduate Hospital of Columbia University.

Dr. Jack C. Warburton

On September 6, Jack C. Warburton, M.D., a member of our Passaic County

component, died in the Community Hospital at Huntington Beach, California. Dr. Warburton recently had moved to Laguna Niguel, California. Born in 1906, he was graduated from Georgetown University Medical School in 1931, and specialized in orthopedic and traumatic surgery. Later he concentrated on emergency room practice, serving at Valley Hospital in Ridgewood. Prior to that he had been on the staffs of St. Joseph's and Preakness Hospitals in Paterson in the department of orthopedic surgery. Dr. Warburton was a Fellow of the American College of Surgeons. He served in the United States Air Force during World War II, attaining the rank of major.

Dr. James H. Willson

One of Essex County's senior members, James H. Willson, M.D., formerly of East Orange, died on August 3 after a long illness. He was living in retirement in Henderson, North Carolina. Born in 1899 and graduated from Emory University School of Medicine, class of 1924, Dr. Willson pursued graduate work at Edinburgh University (Scotland) and then practiced obstetrics in East Orange until retirement in 1960. He had been a member of the obstetrical staff at the Orange Memorial Hospital.

Dr. Wm. F.J. Wittenborn

A well-known Trenton surgeon, William F. J. Wittenborn, M.D., died on August 14 in Helene Fuld Medical Center where he had been a member of the surgical staff for many years. A native of Trenton, born in 1908, Dr. Wittenborn was graduated from Hahnemann Medical College in 1933. He was affiliated with Helene Fuld Medical Center all of his professional life and served a term each as chairman of the department of surgery and president of the medical staff. Two of his three sons are practicing physicians—one in Allentown (NJ) and one in Atlanta, Georgia.

Emergency Care Handbook: How To Deal with People in Emergencies.

A. R. Cianutti. Westport, Ct., Technomic Publishing, 1977. pp. 100 (no price listed)

This book was written for those individuals, professional and non-professional, working in emergency medical situations, both in and out of hospitals. It is concerned primarily with a philosophical and psychological analysis of the emotional aspects and reactions of not only the patient, but of those in the hospital emergency department. The author speaks of the patient's feelings and his perspective while lying on the stretcher as he is being wheeled into the emergency department. If he is conscious, he wants compassion and understanding. There may be some relative disorientation that will require much consideration and tuning in on his wavelength. The patient's problem must be identified in a satisfactory manner. The author's questioning of patients is time-consuming and in a busy emergency department wasted. The author states that "every patient who comes to the emergency department is experiencing an emergency." This is a fallacious statement as is well known by all those working in emergency departments. In an emergency, leadership and teamwork are essential by training and not by philosophical reactions to a patient. His chapter on "Pretending To Know" appears superfluous. If we are to work in an emergency department, we should be trained for the required duties or obtain the desired training without any pretention. The author contradicts himself by saying "stress is an unnecessary element in many emergency department situ-

ations." In another chapter entitled "Code Blue," he states "in most emergency departments . . . stress can be useful; it gives the members of the medical care team the energy they need to be equal to the emergency."

I hesitate to recommend this book to any trained physician or nurse in emergency medicine. It may be of some value in a psychology or philosophy class.

Jack R. Karel, M.D.

The Malpractitioners

John Guinther. Garden City, N.Y., Anchor Press/Doubleday, 1978. pp. 347. (\$10).

The Malpractitioners by John Guinther, a visiting professor of urban affairs at Temple University, an investigative reporter whose articles have appeared in a number of publications, and a contributing editor for *Philadelphia Magazine*, attempts a kaleidoscopic review of the medical malpractice crisis in the United States. As evidence of his investigative reporter background the author has documented his book with a multitude of statistical information, which has come from customarily cited sources, including the American Medical Association, the American Bar Association, the HEW Commission on Medical Malpractice, the insurance industry, and others.

Mr. Guinther has attempted to flavor his voluminous supporting data with brief, well-written clinical examples of malpractice, the sources of which have been left anonymous at the request of the informing parties. Mr. Guinther states: "Several of these source people, whose employment might be jeopardized if their cooperation became known, spoke to me only on the promise they would not be named or be other-

wise identifiable." These malpractice examples are well written and pro-plaintiff. They make captivating reading but are inadequate in number to maintain the reader's interest in the face of such heavy statistical data.

The author deserves praise for his depth of review of the malpractice crisis. Mr. Guinther takes a decisive look at the roles of all the players in the crisis, including patients, physicians, hospitals, lawyers, judges, juries, politicians, and drug manufacturers. He measures the gains and the losses of each player in the malpractice crisis.

The Malpractitioners also deals with some other items which are not related directly to medical malpractice. Among these are unnecessary surgery and the historical, political, and economic impact of foreign medical graduates on American medicine.

Finally, the author makes some suggestions about solving the malpractice crisis. (1) institute non-binding arbitration for resolution of malpractice disputes; (2) provide free medical evaluation in malpractice disputes; (3) exclude the plaintiff attorney's fee from the jury verdict according to some agreeable formula; (4) provide malpractice insurance to all providers on a flat-rate basis; and (5) malpractice insurance should be written by a national company operating under federal guidelines.

Space does not permit evaluation of these recommendations. No new and startling solutions are offered. However, this reflects the nature of the subject matter rather than the abilities of the author.

The Malpractitioners is an in-depth, comprehensive review of the malpractice crisis. It is an excellent book for the uninformed. It is doubtful that the physician reader will learn anything new.

James E. George, M.D.

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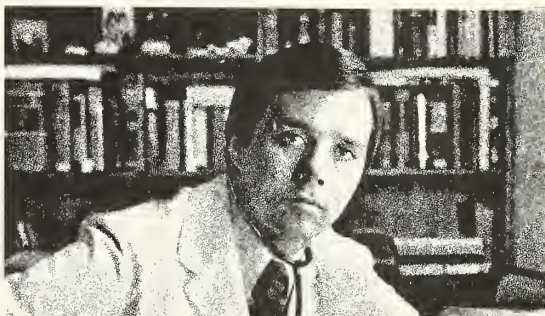
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DESCRIPTION: Methyltestosterone is 17 β -Hydroxy-17-Methylandrosta-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric,

avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE**

REACTIONS: Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. In the male: Eunuchoidism and eunichism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahoglu, M.D.: Hormones for Improved Sexuality in the Male and the Female Climacteric. *Drug Therapy*, Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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213th Annual Meeting
May 12-15, 1979
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Dear Doctor,

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from all of us to all of you.*

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bring you much happiness.*



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Substitution? It's Your Option!

Many New Jersey physicians are unaware that the proprietary medication which they have prescribed may be dispensed as a generic preparation. Effective September 29, 1977 (L. 1977, c. 240, Sec. 24:6E), the "Prescription Drug Price and Quality Stabilization Act" gave pharmacists both the right and the obligation to substitute.

Like motherhood and apple pie, at first look one might have only kind thoughts toward the concept of substitution. After all, it will give our patient a first-rate medication, which will be exactly what he needs and what we want him to have, and it will save him a good deal of money. Or will it?

Although the Medical Society of New Jersey basically was opposed to the repeal of the old anti-substitution law (written to curb the abuses of a few pharmacists) and passage of a substitution law, the negotiations between the Society and the Legislature ultimately reached an impasse which forced the Society to accept the best bill it could get.

The essence of the existing New Jersey drug substitution law is as follows:

(1) The Department of Health was required to establish a Drug Utilization Review Council (two licensed pharmacists, two licensed physicians who have pharmacological experience, three persons with professional scientific or research experience in pharmacology, and two members of the general public).

(2) The Council prepares a list of interchangeable drug products and must distinguish whether evidence of bioequivalence and levels of toxicity are considered critical. United States government agency lists of interchangeable drug products, "where the government or such agency has established the reliability of the drug products interchanged," may be included.

(3) Public hearings shall be held to discuss drug products before they can be included in the list.

(4) Manufacturers must divulge, on request, detailed information concerning manufacturing processes, *in-vivo* and *in-vitro* tests as to bioavailability of any drug product, and technical research data, although the Council is forbidden to divulge such information to the public "where there is a proprietary interest on the part of the manufacturer."

(5) The list of interchangeable drug products shall be distributed to physicians and other authorized prescribers, to licensed pharmacists, and to any other person on request.

(6) Every prescription blank shall be imprinted with the words "substitution permissible" and "do not substitute" and shall contain space for the physician's or other prescriber's initials next to the chosen option.

(7) Unless the physician exercises his "do not substitute option," either for an oral or written prescription, the pharmacist is *required* to dispense a substitute drug product if it will reflect a lower cost to the consumer and it appears on the list.

(8) Where the physician permits substitution and requests notification of such substitution, the pharmacist is required to comply orally or by written notice.

(9) No drug interchange is permitted unless a saving to the consumer results and the pharmacist passes such savings on to the consumer *in full*.

(10) Where substitution is indicated and prior to having his prescription filled, the consumer may request the pharmacist to inform him of the price saving that would result from substitution. If the consumer is not satisfied with the price saving, he may require the pharmacist *not* to substitute.

(11) The pharmacist is required, with *authorization by the physician*, to substitute a different brand name or non-brand name product *which does not appear on the list* if, in his professional judgment "there is no valid proof of efficacy for the drug product prescribed, or the pharmacist's patient profile record discloses drug sensitivity, allergies, or adverse reactions to the drug product prescribed, or there exists a more appropriate drug product than the drug product prescribed." Of course, substitution here again is supposed to reflect lower cost to the consumer.

(12) If a non-brand name drug product is dispensed, the pharmacist is required to include the established name of the drug or the name of the manufacturer on the label *unless the physician forbids such labeling*.

(13) Failure of the physician to utilize the form of the prescription described in the Act *does not* invalidate the prescription as written, if said prescription is otherwise valid.

How has this consumer-oriented type of legislative effort been received by the involved parties? Is it accomplishing the goals of its authors? Is it really motherhood and apple pie? Does New Jersey differ from other states in our area? The last question is easiest to answer. Like New York, Connecticut, Massachusetts, Pennsylvania, Ohio, and Delaware our state allows substitution. Altogether there are only seventeen states which have anti-substitution laws at present.

From the *pharmaceutical manufacturers'* viewpoint there is a good deal wrong with substitution laws. The manufacturers expend a good portion of their annual budget—millions of dollars—to research and develop new products. From the germ of an idea to the patient's medicine chest is a long, tedious, and expensive road which is filled with potholes and barriers placed by the United State FDA and others. *In-vitro* research, animal studies of toxicity, efficacy, and bioavailability, and human studies of safety and efficacy are inordinately expensive. FDA requirements have become so stringent that it hardly pays to embark on this course unless the manufacturer has such an unique product that success is almost guaranteed. Quality control in manufacture, another costly item, is essential. Furthermore, marketing through ethical advertisement to professionals is not only expensive but less likely to produce the results that comparable market-

ing efforts to the general public could assure. Not only does the pharmaceutical manufacturer contend with legitimate market-place competition, he now has two new competitors—the illegal pharmaceutical counterfeiter who easily may produce useless, unsafe, unpure, blatant imitations in a garage or unsavory warehouse, and the manufacturers of “look-alike” generics who spend little or nothing in research and development, bioavailability studies, and quality control. Many such generic drug products are manufactured in foreign countries so their importation to the United States adds to our balance-of-trade deficit.

Thus, the substitution laws, in effect, have legitimized and enhanced the position of the generic drug manufacturer whose major motive is profit, while pushing aside the respected major pharmaceutical manufacturers who have held their reputation for the development of safe and effective products for the ultimate good of the patient and service to physicians and allied professionals as paramount. The service of such corporations to this nation over the last fifty years deserves greater recognition.

Since pharmaceutical manufacturers are dependent on their earnings to stay in the laboratory and in business, substitution laws cannot help but have adverse effects. They may force the very best to curtail expensive research or markedly diminish it and to cut costs—for example, in quality control and service to the medical profession through educational grants. They even may encourage the best of drug houses to enter the field of generic drug product manufacture in order to protect their financial interests.

Finally, it is no small matter to the pharmaceutical manufacturers to divulge to the Council detailed information about their research and manufacturing processes, which may have cost large amounts of time and money to obtain, with the rather thin assurance that the information will not be divulged if the manufacturer “has a proprietary interest” in drugs he has developed. Obviously he has a proprietary interest in drugs he has developed; it would be unlikely that the manufacturer would wish to volunteer such information and risk divulgence of what might be very confidential information. What other industry in America is placed in such a position?

The thoughtful, honest *pharmacist* also has reason for concern. He now is put into a semi-adversary relationship with the physician and the consumer when he complies strictly with the requirements of the substitution law. Furthermore, he is in the odd position of at once having to provide scientific justification to the consumer that the substitute drug is satisfactory and also haggling with him over price. His legal liabilities are greatly enhanced because he warrants that the substitute product is safe and appropriate, at least by implication, which means his judgment now makes him liable to suit should something go wrong and the consumer claims an injury. He is especially at risk on the issue of bioequivalence, since there is little or no reputable laboratory bench evidence of such for many or all of the generic products which filter into the drug marketplace. The pharmacist also may have the added burden of contacting the physician to discuss substitution, which is no easy matter in the lives of busy pharmacists and physicians. He must, of course, constantly deal with the approved list, but also has the burden of non-listed, non-brand products, and alternate proprietary drugs as well. The pharmacist must maintain and refer to each patient's prescription profile record on a regular basis. All of this professional activity, along with the normal

risks of doing business, must occur within the constraints of the “maximum allowable cost” concepts. This is not an enviable position!

What about the *patient*? He obviously wants the medication his physician feels is best for his condition but, cost of living being what it is, he wants the least expensive product. He now has the responsibility to inquire as to savings while demanding assurance that the substitute drug product is not cheap but ineffective. Patients today expect almost instant cure of every ailment, so where their expectations are not met in 36 or 48 hours, they now may suspect the medication rather than the illness. Compliance with drug prescription directions has been notoriously poor and it is not likely to improve under the substitute drug program.

Finally, the physician finds himself in another situation which is relatively new to him. We all have lived with the drug substitution programs within our hospital pharmacies, but have had the opportunity through pharmacy committees to select and modify the drug list to meet our standards of high quality and efficacy. We did not concern ourselves with the bioavailability of tetracycline manufactured in Italy or other such drug products. We also have lived with lists—public welfare programs, veterans administration and army pharmacies, and Medicaid programs which have had them for years. It is new to have our private office patients demand generic equivalent prescriptions because they have been advised to do so by consumer advocates. It rankles the individualistic physician, who chooses to prescribe what drug he thinks is best, based on his professional experience and judgment, to assume a stance of critical vulnerability by a program he did not want. Physicians all have read reports of bioavailability studies of generic prednisone and digoxin and similar potent medications which showed wide variability in content. The generic prednisone tablet which contains 2.8 mg of effective prednisone instead of the expected 5 mg cannot give the clinical results one would expect. Likewise, the generic digoxin tablet which contains 0.3 mg rather than 0.25 mg could produce toxic effects in time. These are considerations which will become much greater when across-the-board substitution takes place.

We have no idea whether the substitution program is doing the great things for consumers it was touted to do. Studies have cast doubt on the extent of cost savings to the patient. At the same time, the public has been taught that the pharmacist may take advantage of him if he is not careful, so that important position of mutual trust between pharmacist and patient, like the critical doctor-patient relationship, now may be tenuous.

What position should the physician take? *He should remain right in the driver's seat where he belongs!* He knows the medical problems of his individual patient better than anyone. He knows what drug products are and do. He also knows his responsibilities and his liabilities.

The law permits the physician to indicate very clearly on his prescription blank—“*do not substitute.*” If physicians want to remain in control of the drug products they prescribe, they clearly should exercise that option. The physician who knows his local pharmacist well and trusts his advice and judgment may approve generic substitution in all or in selective cases. But, he should be well aware of the situation and understand that substitution will occur if he passively ignores making a decision for every prescription he writes.

A.K.

Community Mobile Cardiac Life Support

In this issue of *The Journal*, (p. 899) Yablonski and Yekanath describe their remarkable experience with New Jersey's "first successful and sustained initiative for heart rescue" in a most convincing manner. Employing already existing facilities and personnel at the level of the community hospital, they have produced first-class results with minimal fanfare, little or no grant support, and none of the traditional trappings of academe. The authors lucidly delineate the efficiency of the system and its economic feasibility while maintaining a refreshingly conservative attitude with statements like "These measures *probably* prevented *some* deaths from acute ischemic heart disease."

What are the implications for New Jersey's "front-line" primary physicians? It is no secret to any of us that nearly half of the deaths due to ischemic cardiac insults occur relatively suddenly owing to electrical mishaps in hearts otherwise "too good to die," and that most of these dysrhythmias, at least theoretically, are reversible. Yet, even the most sophisticated CCU has little to offer because of its immobility and because of unwarranted delays owing to patient, physician, transportation, and other factors. Nearly

two decades of experience with a variety of "mobile CCUs" has shown that early diagnosis and therapy significantly can prevent and reverse fatal dysrhythmias in patients with acute ischemic cardiac episodes. However, many of the pioneering efforts were mired in problems related to cost-efficiency, inadequate patient and physician education, inadequate personnel and equipment, failure of community support, traffic congestion, inordinate "false-alarms" and poor statistical analyses. The "Community Mobile Advanced Cardiac Life Support" described by the Hackensack group provides us with an elegant model for the prevention of early deaths in acute ischemic cardiac episodes and obviates most of the difficulties listed above. Hopefully, this concept will be adopted in other communities throughout the state where it will be supported enthusiastically by local hospitals, physicians, and patients.

In my opinion, the program of Yablonski and Yekanath offers a rational approach to the frustrating dilemma of sudden death that plagues all physicians. This paper shows what real doctors can accomplish, and I urge all of our readers to spend some time with its content.

Edwin L. Rothfeld, M.D.

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Community Mobile Advanced Cardiac Life Support

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During a four-year period, two thousand patients in Hackensack received care from a mobile heart rescue team staffed by medical resident physicians and critical care nurses dispatched from the hospital. Provision of basic life support and early definitive advanced life support prior to hospitalization resulted in 41 lives definitely saved; 15 of these patients were discharged from the hospital to resume active life. On an annual basis, per 100,000 population, this would represent 42 definite saves with 15.3 long-term saves. The benefits of pre-hospital Advanced Life Support are described. Development of a total community advanced life support system utilizing paramedics supervised via ECG telemetry is discussed.

The Executive Board of the World Health Organization states that coronary artery disease has reached enormous proportions and is striking at younger subjects. This epidemic trend can be reversed only by concentrated research into its cause and prevention.¹ The ideal solution would be in primary prevention, but for the present, secondary prevention remains a major consideration. Furthermore, it is difficult to identify the individual prone to sudden cardiac death, much less to institute effective preventive treatment.

Coronary artery disease, with or without myocardial infarction, is the largest single cause of death in the United States; it accounts for nearly 700,000 deaths a year. At least forty percent of these deaths take place during the first hour when fatal arrhythmias are most likely to occur² and over two-thirds of the deaths occur before the patient reaches the hospital.^{3,4} It is estimated that the number of cardiovascular deaths in the State of New Jersey this year will be 35,800. This is 54 percent of deaths due to all causes.⁵

More than 180,000 sudden cardiac deaths occur per year in the United States in victims under the age of 68, who die before they reach a hospital. With a concentrated effort to develop adequate emergency cardiac care, some 100,000 Americans dying each year could be salvaged.⁶

Recognizing the need to extend prompt emergency care to the heart victim, a physician-staffed mobile coronary system was established in Belfast, Northern Ireland, in 1966.⁷ This

was followed by emergency cardiac care systems of varying sophistication throughout the United States and worldwide.

Evidence that early coronary care is better than late coronary care is accumulating. Hospital mortality among all patients managed by a mobile intensive care unit is approximately one-third less than mortality among patients admitted to a coronary care unit in the usual way.^{8,9} Early coronary care with pain relief, arrhythmia control, and oxygenation may reduce muscle loss and prevent complications. Reduction of pre-hospital, ambulance, and community coronary death rates by a community-wide emergency cardiac care system was shown by Crampton *et al.* in Charlottesville, Virginia.¹⁰ In 1974, Yu¹¹ reported available data from mobile coronary care units or mobile intensive care units in 14 American cities, which showed that about 18 percent of the patients with ventricular fibrillation who were resuscitated successfully left the hospital alive.

The value of community-wide emergency cardiac care systems seems well established. Reports from the United States as well as Ireland, Scotland, Russia, and Sweden have reported a reduction in morbidity and mortality.

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MATERIAL AND METHODS

The Heart Rescue Team consists of a physician and nurse brought to the scene of an emergency in a non-transport emergency vehicle. The vehicle is equipped with oscillating lights and sirens. The equipment, carried in boxes from the emergency room, consists of the following: portable battery-powered defibrillator and monitor (Datascope®), intravenous equipment and a minimum supply of cardiac drugs including morphine, lidocaine, atropine, sodium bicarbonate, calcium chloride, epinephrine, norepinephrine, and meperidine. The personnel includes a medical resident, a critical care emergency room nurse, and a volunteer driver. The team is summoned from various points in the hospital to the emergency room by overhead and radio paging.

The Hackensack community is accustomed to calling the police department for all emergencies, and this established practice was adapted to our system. The department was trained and given the responsibility to screen all calls and to consider those with symptoms such as chest pain, dyspnea, and collapse as cardiac calls. On receiving an emergency cardiac call, the police department contacts the hospital emergency room through a special direct line, simultaneously dispatching an ambulance with EMT (Emergency Medical Technician) personnel to the scene.

The service was initiated on February 14, 1974 as a hospital outreach cardiac rescue program answering calls in the evening and night hours (6 p.m. to 8 a.m.) with the Hackensack Volunteer Ambulance Corps responsible for the dispatch of the ambulance and transport of the patient with Heart Rescue Team to the hospital. In November 1975, the Heart Rescue Team was able to expand coverage to a 24-hour service with the help of the Hackensack Fire Department and Volunteer Heart Rescue Drivers. The fire department is responsible for the ambulance service during the daytime (8 a.m. to 6 p.m.). The Heart Rescue Team services a resident population of about 38,000, which almost doubles during daytime hours due to the influx of workers and

shoppers in an area of 4.6 square miles. There are 500 beds in the community hospital with a 14-bed medical special care unit. The emergency room which is fully equipped to receive coronary patients and treat cardiac emergencies, is staffed by critical care trained nurses, full-time physicians, and medical residents.

The non-transport vehicle, with the team and equipment, travels to the scene of the suspected cardiac patient as rapidly as possible. On arrival at the scene of a cardiac emergency, a rapid general and cardiac assessment is made by the physician and nurse. If a cardiac problem is suspected, oxygen is administered and an intravenous life line is started. Continuous electrocardiographic monitoring for rhythm is mandatory. Chest pain is relieved with four mg of morphine sulfate intravenously; it is repeated as necessary. Cardiac failure is treated promptly. Atropine sulfate is given for sinus bradycardia with obvious hemodynamic disturbances. Therapeutic or prophylactic lidocaine is given as bolus of 75 to 100 mg intravenously and an infusion of two to four mg per minute. Arrhythmias are corrected promptly. Precordial thump version is used in witnessed cardiac arrest, as an initial measure. If unwitnessed arrest is encountered by the team, standard basic and advanced life support measures are utilized.^{12,13} The esophageal obturator airway has been found to be very valuable and useful in the field to obtain airway control and prevent aspiration. The hospital coronary care unit thus is brought to the cardiac patient at the scene of the attack.

Like any other team effort, the mobile cardiac unit can function best when an algorithm is designed to guide its action. An algorithm is a predetermined, step-by-step plan of action that has been agreed upon by all persons involved in a specified endeavor. With our experience in the heart rescue team, a management algorithm was prepared (Figure 1) for pre-hospital emergency care.

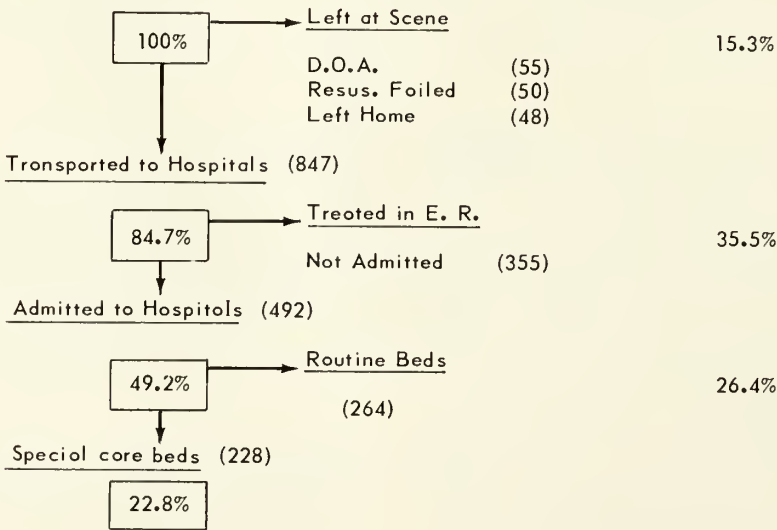
Adequate time is taken to stabilize the cardiac patient's condition.¹³ The patient is then transported in a regular

Table 1
Hackensack Heart Rescue Team Results
First 1,000 Runs (2/15/74-10/9/76)*

Total Ambulance Calls 6,253
Average Duration of Run 25 min.

HRT Utilization 16%
Average Response Time 3.0 min.

Rescue Team Runs (1,000)



*During this period 88 runs (8 percent of total) were recalled and are not included.

EMERGENCY CALL

ALS TEAM AT THE SCENE

- 1) General Assessment
- 2) Clinical Assessment
- 3) ECG Monitoring (optional)

Suspect cardiacs
 Rhythm disturbance
 Severe trauma with or without shock
 Shock due to any condition
 Impaired consciousness
 Hemorrhage
 Respiratory difficulty

COMMUNICATE WITH MEDICAL CONTROL IMMEDIATELY Assessment

-
COMMUNICATION PROCEDURE

 1) Identify vehicle
 2) Report -
 a) Patient sex and approximate age
 b) Patient problem or complaint
 c) State of consciousness
 d) Pulse, respirations, BP, pupils
 e) Assessment of problem and severity
 f) Any important past history or known allergy
 3) Ask for and await orders
 4) Proceed as ordered
 5) Acknowledge when patient is ready for transport
 6) Continue or re-establish communication if necessary

CARDIAC ARREST

No pulse
 No respirations
 Unconscious

UNWITNESSED ARREST

WITNESSED ARREST

chest thump -> na pulse ->

- 1) Initiate Basic Life Support
- 2) Oxygen therapy, esophageal obturator airway
- 3) ECG monitor and treat according to rhythm (next page)
- 4) Establish IV line - D₅W
- 5) NaHCO₃ - 1 amp. 50cc. IV q. 10 minutes

pulse returns ->

Suspect Cardiac

- 1) Initiate and continue oxygen therapy
- 2) Monitor ECG rhythm (next page)
- 3) Start or maintain IV line - D₅W
- 4) VS and BP q. 3 minutes
- 5) Further clinical assessment

BP

< 90 mm Hg
 Pt. cold & clammy

> 90 mm Hg

CHEST PAIN

MS 4 mg IV
 Lidocaine 75-100 mg IV bolus
 and drip: 2-4 mg/min.

HEART FAILURE

Drug therapy as ordered

Dopamine 2 to 20 mcg/kg/min. to maintain BP at 90

Further total body clinical assessment

History of trauma or illness other than cardiac

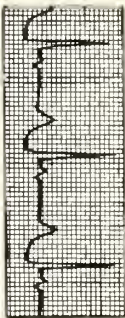
1) Further total body clinical assessment
 2) BP < 90 mm Hg; patient shocky - start IV Ringer's lactate solution
 3) Obtain homeostasis
 4) Medicate for discomfort
 5) Package for transfer

TRANSFER TO HOSPITAL

(Figure 1 cont'd)

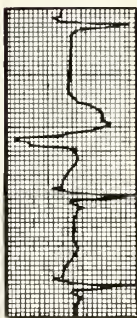
- RHYTHMS -

NSR:



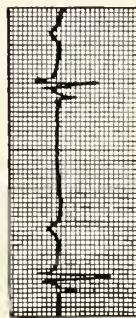
- 1) Oxygen
- 2) Maintain IV line
- 3) MS 4 mg for chest pain or medicate for discomfort
- 4) Lidocaine 75-100 mg IV bolus followed by drip of 2-4 mg/min if suspect MI below age 70

NSR with VPC's:



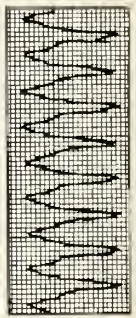
Lidocaine as above and if VPC's are not controlled, repeat Lidocaine 50 mg IV bolus after 15 minutes.

SINUS BRADYCARDIA:
<50/min with signs of
hypotension or VPC's



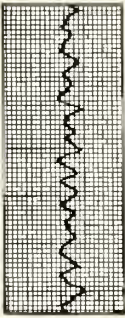
Atropine 0.5 mg IV. If no response, then repeat after 4-5 minutes until maximum dose of 2.0 mg.

VENTRICULAR TACHYCARDIA:



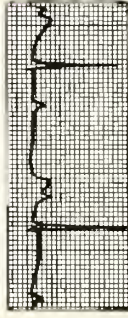
Patient Unconscious -
Lidocaine bolus + cardioversion 400 watt/sec.
Patient Conscious; BP >90 mm Hg -
Lidocaine bolus 100 mg IV followed by drip of 2-4 mg/min.

V-FIBRILLATION:



- 1) Basic Life Support - continue or initiate
- 2) D/C shock 400 watt/sec.
- 3) NaHCO₃ q. 10 min. - 1 amp
- 4) Epinephrine, 5-10 cc in 1:10,000 IV

COMPLETE HEART BLOCK:



Atropine 0.5 mg IV. If no response, then repeat after 4-5 minutes until maximum dose of 2.0 mg. If no response with severe bradycardia and hypotension, Isoproterenol drip 2 to 20 mcg/min.

ASYSTOLE OR ELECTRO
MECHANICAL DISSOCIATION:



- 1) Continue or initiate Basic Life Support
- 2) Epinephrine 10 cc 1:10,000 IV q. 2-5 minutes as needed
- 3) NaHCO₃ - 1 amp 50 cc q. 10 mins. IV
- 4) Calcium chloride 10% - 5 cc IV

Table 2

*Hackensack Heart Rescue Team – First 1,000 Runs
Camman Emergencies Involving 667 Patients*

Ischemic Caranary Events	147
Acute Pulmanary Edema	96
Cardiapulmonary Arrest	91
Syncape and Dizziness	77
Non-Cardiac Chest Pain	69
Acute Myacardial Infarction	63
Dead on Arrival	55
Respiratory Disease	43
Arrhythmias	33
Seizures	25
Overdose	15

(Patients with miscellaneous diagnoses 333)

ambulance, with lights but no siren, accompanied by a nurse and physician with continuous electrocardiographic monitoring. Thus, the patient is maintained in the coronary care unit environment throughout the transportation to the emergency room and treated as necessary in the ambulance. The heart rescue team and the emergency room are in constant radio communication with each other.

In cases such as trauma, hypotension, ruptured aneurysm, intractable pulmonary edema, the goal was initiation of essential treatment and immediate transportation.

When the emergency cardiac care service was started, a public information and education campaign was initiated by the Bergen County Chapter of the American Heart Association through various mass communication media. The public was alerted to recognize the early signs and symptoms of coronary artery disease. The importance of early entry into the emergency cardiac care system was stressed. The public was advised to take appropriate action and quickly to summon the Heart Rescue Team.

RESULTS

From February 15, 1974 through September 1976, the Heart Rescue Team made 1,000 runs. Total ambulance calls during this same period were 6,253, therefore, the Heart Rescue Team was utilized in 16 percent of all calls. The median time from the call for help to arrival at the patient's side averaged four minutes or less. Calls for the unit were distributed evenly throughout the day and week with a decrease in calls between 11 p.m. and 7 a.m., suggesting that people may wait until the morning to call or that they may utilize some other type of transportation at night. The average duration of a run was 25 minutes (98 percent of them were completed within 45 minutes). Almost 90 percent of the calls were from home.

Disposition outcome of these 1,000 calls is shown in Table 1. Forty-eight patients (4.8 percent) were left at home since they did not require hospital treatment. Three hundred fifty-five (35.5 percent) were treated in the emergency room and sent home. Half the patients needed hospital admission as an emergency and half of these patients (22.8 percent) were admitted to special care units (ICU and CCU). Eighty-eight runs were recalled or cancelled and are not included.

The distribution of responses is shown in Table 2. Seven-hundred and fourteen events are shown involving 667 patients. The patient's hospital records were studied and cardiac diagnosis was firmly established. One hundred forty-seven calls (14.7 percent) were due to ischemic coronary events. There were 96 (9.6 percent) episodes of acute pulmonary edema at the scene which was confirmed in the emergency room. Of these, six had cardiopulmonary arrest

Table 3

*Hackensack Heart Rescue Team – First 1,000 Runs
Resuscitation Results 2/14/74-10/9/76*

	Number	Percent
Resuscitations		
Unsuccessful (12 F, 38 M)	50	55.0
Survivors (14 F, 27 M) Number 41 (45%)		
Short Term (Avg 6 Days)	26	28.5
Long Term (19.5 – 44 Mas to Date)	15	16.5
Total	91	100.0

before admission and 9 proved to have acute myocardial infarction. Of the 77 patients with syncope attacks or dizziness, only eight were due to arrhythmias. Acute myocardial infarction was proved in 63 patients (6.3 percent) which includes 17 patients resuscitated at the scene.

A total of 444 cases were seen by the team as a result of acute ischemic heart disease manifested as ischemic coronary events, cardiopulmonary arrests, acute pulmonary edema, dead on arrival (DOAs), or arrhythmias. DOAs are presumed as sudden deaths due to coronary artery disease. There were another 69 patients in whom acute ischemic heart disease was suspected at the scene but the origin of chest pain proved to be non-cardiac. The diagnoses of 333 patients are not shown in the tables but many of them had important medical conditions requiring attention.

Of 46 patients with acute myocardial infarction who were admitted by the rescue team, 4 patients died in the critical care units. This resulted in a mortality of 8.7 percent. Table 2 indicates 63 cases with this diagnosis, however 17 patients were excluded from the mortality rate because they were resuscitated at the scene. The four who died were over 60 years of age and died between 7 and 21 days of admission. Sixty-six percent of all acute myocardial infarctions were males.

Eighty-three patients with acute pulmonary edema were admitted (excluding the cases with associated CPR at the scene and myocardial infarction) and only three died. The three patients who died were over 72 years of age and each had associated medical conditions such as cerebral vascular accident (CVA), mesenteric thrombosis, and acute renal failure. The mortality rate is 3.6 percent.

The Heart Rescue Team initially was designed primarily to bypass the delays in getting patients into a coronary care system and not to treat sudden death. However, a total of 91 patients during the first thousand runs were found to be in cardiopulmonary arrest (Table 3). Pre-hospital cardiac arrest occurred in 27 percent of the patients with proved acute myocardial infarction. Most of the arrests occurred at home, and three of them on the way to the hospital or while being admitted to the emergency room. Thirty-seven of the cardiopulmonary arrests were probably in arrest for more than five minutes. In 50 of the patients (54 percent) cardiopulmonary resuscitation was unsuccessful. The cause of arrest in these cases is not known except in one where autopsy showed acute myocardial infarction.

Forty-one patients (45 percent) were resuscitated successfully at the scene by the Heart Rescue Team and were admitted to the hospital. There were 27 males and 14 females. Etiology of arrest in the 41 patients is shown in Table 4.

Twenty-six of the successfully resuscitated survivors died later in the critical care unit or in the emergency room after an average survival time of six days. Fifteen patients who were resuscitated by the Heart Rescue Team were discharged to home alive. Details regarding the patients are given in

Table 4
Survivors of Cardiopulmonary Resuscitation
Etiology of Cardiopulmonary Arrest

Acute Myocardial Infarction	17
Pulmonary Edema (2)	
Acute Ischemic Coronary Event	9
Pulmonary Edema (4)	
Miscellaneous*	8
Unknown	7
	41

* 1 each — RHD, Sepsis, trauma, drug overdose, asthma, COPD, electric shock, choking-aspiration

Table 5. Preliminary analysis of the next thousand calls reveals that of 73 outside-the-hospital resuscitation attempts, 18 were successful (24.7 percent) and admitted to the hospital.

DISCUSSION

The System—There has never been any doubt that the majority of deaths from coronary artery disease occur early and this fact prompted the development of the Heart Rescue Team. The expense of a dedicated specially equipped mobile intensive care unit with standby medical manpower probably was not justified. The Heart Rescue Team as described, manned by a medical resident and a trained nurse who are already on duty made it economically feasible and efficient. Physician and nurse units have operated successfully in Belfast, Charlottesville, Dudley, New York and elsewhere.^{9,10,14,15} This was the first successful and sustained initiative for heart rescue in the State of New Jersey. Existing community facilities were utilized and the system was adapted to the community's needs. Our experience indicates that 84 percent of all calls from the community can be handled by ambulances manned by EMT-I personnel. This confirms previous observations in Pittsburgh where a survey determined that 85 percent of the patients brought to the emergency room do not require pre-hospital advanced life support.¹⁶

It is important to note that the response time to reach a heart victim by mobile advanced life support is four minutes or less. This is possible with a dense population in a small geographic area, but more difficult to achieve in large cities with traffic congestion or in thinly populated rural areas. That these problems can be overcome has been demonstrated by the Seattle program, where less specialized units are backed up by one or two vehicles with advanced life support capability. Prompt response time coupled with the availability of bystander cardiopulmonary resuscitation is necessary for a program to treat sudden cardiac deaths.

Arrhythmias—Multi-focal or frequent ventricular ectopic activity was treated promptly by the mobile cardiac team, resulting in a decrease in life-threatening arrhythmias which, however, is not quantifiable. All suspected cardiac patients under 70 years of age now receive prophylactic lidocaine intravenously. Lidocaine has been shown to reduce the incidence of ventricular tachycardia and fibrillation in the early phase of acute myocardial infarction resulting in a reduced mortality.^{17,18,19} Lidocaine dosage is reduced in patients with liver disease, congestive heart failure, and in the aged.

Deaths During Transportation—Coronary deaths during ambulance transportation to the hospital have been reported as 18 percent of all pre-hospital coronary deaths.^{4,10} In Nassau County, 1728 patients with chest pain were monitored with ECG telemetry by ambulance personnel.

Ventricular fibrillation was found as the initial rhythm in 8.1 percent and 22.9 percent had other significant arrhythmias, while one percent developed cardiac arrest in route to the hospital.²⁰ Crampton *et al.* reported a 62 percent decrease in coronary deaths in ambulances with pre-hospital care.¹⁰ In the present series, three patients developed cardiopulmonary arrest while being attended by the Heart Rescue Team and were resuscitated successfully. None died during transportation. Therefore, the addition of pre-hospital advanced life support is a major element of a comprehensive community emergency medical service.

Pre-Hospital Treatment—A substantial number of patients with acute ischemic coronary events, acute pulmonary edema and arrhythmias were benefited at home and during transportation by prompt and appropriate treatment by the Heart Rescue Team. These measures probably prevented some deaths from acute ischemic heart disease. The prompt treatment of cardiac failure may improve cardiac perfusion and limit the extent of infarcted tissue²¹ and may decrease the incidence of cardiogenic shock.²²

Hospital Mortality—The overall mortality for patients with acute myocardial infarction in our coronary care unit is 15 percent. The hospital mortality for patients with acute myocardial infarction who received pre-hospital care by the Heart Rescue Team and did not require resuscitation is only eight percent. A mortality rate of approximately eight percent among patients with acute myocardial infarction arriving under mobile coronary unit within the first hour was shown by Pantridge⁹, Grace²³, and Lewis *et al.*²⁴ Pantridge reported a reduction in hospital mortality from 22.8 to 12.3 percent⁹ and Walsh *et al.* reported a reduction from 23 to 9 percent⁸ in patients admitted by mobile coronary unit as compared to patients brought to the hospital by conventional means.

Pantridge attributed part of this improvement to a reduced incidence of shock and pump failure in patients who were treated early.²⁵ The reduction in the hospital mortality rate supports the concept that early treatment provided by mobile coronary units is of benefit in aspects other than the reversion of malignant arrhythmias. Hospital mortality in acute pulmonary edema managed by the Heart Rescue Team was also low.

Out-Of-Hospital Resuscitations—As mentioned earlier, the Heart Rescue Team initially was designed to facilitate rapid entry of patients with acute ischemic heart disease into the coronary care system. However, a large number (9.1 percent) of calls were found to be due to cardiopulmonary arrests and similar experience is reported in other programs.^{10,20,26} We found that the concept of treating sudden out-of-hospital cardiac deaths was possible by utilizing a heart rescue team in our community.

Prompt definitive pre-hospital emergency medical care definitely saved 41 lives out of which 15 patients were discharged from the hospital to resume active life. Thus, 16.5 percent of persons resuscitated outside the hospital were long term "saves." An analysis of the experience of the last decade reveals that almost 20 percent of the persons with a cardiac arrest in the hospital or emergency room survived to be discharged from the hospital.²⁷ On an annual basis, per 100,000 population, our results would account for 42 definite saves with 15.3 long-term saves. Czachowski, in a recent study, reported corresponding rates as 18.5 definite saves with 6.9 long-term saves.²⁸ In a similar type of analysis, Crampton reported 5.8 long-term saves and 13.4 saves for 30-69 aged population.¹⁰ The corresponding rate for the age

Table 5
Hackensack Heart Rescue Team — 1,000 Runs
Long-Term* Survivors of 91 Resuscitation Attempts 2/14/74-10/9/76

Non-Cardiac Events (5)

Run #	Age	Sex	Response Time (Min.)	# Shocks Delivered	Diagnosis	Followup (5/78)
66	25	M	4	—	Respiratory arrest, narcotic overdose	Lost to follow-up
172	26	F	2	—	Respiratory arrest, bronchial asthma, overdose	Active life 44 mos. to date
719	31	F	4	2	Choking-aspiration, ventricular fibrillation	Active life 26 mos. to date
999	49	M	1	3	Electrical shock, ventricular fibrillation	Active life 19.5 mos. to date
1071**	73	M	3	—	Respiratory arrest, COPD	Lost to follow-up
Avg	41	3M 2F	5	2.8		

Cardiac Events (10)

Run #	Age	Sex	Response Time (Min.)	# Shocks Delivered	Diagnosis	Followup (5/78)
90	68	M	3	1	Acute inferior MI, ventricular tachycardia	Lived 28 mos.; died ruptured aneurysm
210	74	F	3	1	Pulmonary edema, cardiac arrest	Lost to follow-up
221	62	F	5	1	Acute inferior MI, ventricular fibrillation	Active life 29.5 mos. to date
280	59	M	3	3	Acute inferior MI, ventricular fibrillation	Active life 40 mos. to date
545	60	M	2	2	Ethanolism, COPD, diabetes, ventricular fibrillation	Active life 31 mos. to date
670	54	M	2	2	Acute anterior MI, ventricular fibrillation	Active life 29 mos. to date
703	61	M	1.5	3	ASHD, acute pulmonary edema, ventricular fibrillation	Lived 24 mos.
755	82	F	2	—	ASHD, sick sinus asystole	Active life 25 mos. to date
794	72	F	2	5	Acute anterior MI, pulmonary edema, ventricular fibrillation	Active life 24 mos. to date
958	52	M	5	2	ASHD, ventricular fibrillation	Active life 19.5 mos. to date
Avg	64.6	6M 4F	2.9		Acute inferior MI 3 Acute anterior MI 2 No MI 5	Avg 28.3 mos. Total 339.5 pt. mo.

* Discharged from hospital.

** Accession numbers include 88 cancelled calls, therefore exceed 1,000.

(MI—myocardial infarction, COPD—chronic obstructive pulmonary disease, Vent. Fib.—ventricular fibrillation, mos.—months)

group in our series would be 32.1 saves per 100,000 annually.

Almost half the patients with cardiopulmonary arrests due to coronary artery disease did not show evidence of acute myocardial infarction. Similar findings have been documented clearly by Baum *et al.*²⁹ and Liberthson *et al.*³⁰ Hence, it is important to treat all acute events due to coronary artery disease aggressively rather than only acute myocardial infarction, since sudden death is at least as frequent with myocardial ischemia alone.

Fifty-five patients (5.5 percent) were found to be dead on arrival of the Heart Rescue Team. Similar figures are noted by other mobile intensive care units. This indicates the need for further study related to sudden death. It may be possible to prevent this by intensive education of the public to call for help early and by training the general public in basic life support.

Our cardiopulmonary resuscitation results show that many victims who die as a result of such accidental causes as asphyxiation by inhalation of food or vomitus, overdose, or electrocution could be saved by modern methods of basic

and advanced life support. Victims of drowning, smoke inhalation, and other life-threatening emergencies such as severe trauma also could be assisted.

Other Benefits—Measures to limit infarct size, which soon may become available, probably will be most effective if applied within six hours of the onset of infarction.³¹ Mobile intensive care units will be helpful in applying such measures to a coronary victim early.

In one study where many patients received pre-hospital care, 80 percent were discharged within 10 days.³² It has been shown that one-third of the patients with acute myocardial infarctions could be discharged on the third day³³ providing they reside in an area covered by adequate pre-hospital care. Thus, the availability of a mobile coronary care unit in a community may help in decreasing hospital stay and the cost of hospital care.

Cost—In our experience with the Heart Rescue Team, the imputed cost for the addition of advanced life support capability to the already-existing community emergency service was \$19.50 per call and \$1,300 per life save. This

estimation includes salaries, equipment, maintenance and drugs.³⁴ With his experience in Charlottesville, Crampton reported that yearly advanced life support cost for 100,000 people would be \$13,181 for physician staff, drugs, and equipment, or \$2,273 for a life save, \$67 per call.³⁵

Development of Comprehensive Community EMS—There has been a gradual and significant increase in the number of runs in subsequent years of the Heart Rescue Team's operation. The need for a comprehensive emergency care program was realized and as a result of the early experience with heart rescue, there evolved a total community advanced life support system to attend all emergencies.

In 1969, Nagel and co-workers³⁶ introduced radio-transmission of the electrocardiogram (ECG telemetry) between mobile units and the hospital for the purpose of implementing early coronary care using trained paramedics staffing an emergency vehicle. Similar programs were developed in Nassau County,³⁷ San Francisco,³⁸ Los Angeles,³⁹ Jacksonville⁴⁰ and Portland.⁴¹ It now is well established that paramedic personnel are capable of correcting ventricular fibrillation outside the hospital.^{30,36,38,39,41} Cobb's Seattle scheme has been particularly successful.⁴² Electrocardiographic telemetry signals may be sent over radio waves and/or via the telephone system. Multiplexing telemetry transmission consists of placing two signals (ECG and voice) on the same channel. Thus, it is possible to transmit ECG telemetry continuously without interrupting the use of the same channel for two-way voice communication. The frequencies involved in the transmission of radio signals are under strict control of the Federal Communications Commission.

Paramedic students⁴³ with a background of at least 150 hours of didactic training were given 400 hours of clinical training in the emergency room and special care units starting August 1977 and over 100 hours of field training with the Heart Rescue Team. All residents and nurses in the emergency room are trained in the use of electrocardiographic UHF telemetry and radio communication and were certified in Advanced Life Support by the American Heart Association.⁴⁴

When the EMT II Paramedics, functioning as part of the Mobile Intensive Care Unit (MICU) Pilot Project, were certified by the New Jersey State Board of Medical Examiners, they initially functioned as a part of the Heart Rescue Team under direct supervision of a physician. As the paramedics gained more field experience, the physician was withdrawn from the field and medical control was established via UHF voice and ECG telemetry. The State of New Jersey Department of Health recently published communication system guidelines for Mobile Intensive Care Units.⁴⁵

The paramedics now are supervised by a critical care nurse member of the Heart Rescue Team. The long-range plan is for paramedics to function under direct medical control, utilizing field supervision on a limited basis as part of a continuing education program.

Hackensack paramedics are part civilian and part firefighter employees of the City of Hackensack under the control of the Fire Department. During daytime hours, both the regular ambulance service and the paramedics are full-time fire department employees. During the remainder, the Hackensack Volunteer Ambulance Corps provides basic life support and transportation, and advanced life support is provided by fire department paramedics responding in a nontransport multipurpose rescue vehicle.

CONCLUSION

Sophisticated coronary care and emergency medical service must be taken to the patient at the scene of the attack where it can be most effective. The system should be adapted to a community's particular needs, resources, and existing emergency facilities. The service should not be limited to coronary patients but rather extend to all emergencies. It is a valuable extension of health care in any community that has a hospital emergency room and coronary care unit. The difficulties in obtaining medical personnel to staff mobile units need not preclude the development of pre-hospital advanced life support. A service staffed by paramedical personnel easily can be developed by utilizing a physician-nurse team initially who provide the framework for an expanded service. The value of paramedic-staffed medical intensive care units has been well established in many parts of the country. In a paramedic program we believe that close supervision by physicians trained in advanced life support is essential. The physicians should have intimate knowledge of the emergency medical service and be familiar with the capability of the paramedics. Medical control is well defined in a "working draft document" issued by the Emergency Medical Services Division of the United States Department of Health, Education and Welfare.⁴⁶ Periodic evaluation of effectiveness of the program is necessary.²⁰

Pre-hospital cardiopulmonary resuscitation by EMT-I qualified personnel has been found to be successful in our community and elsewhere and should be an integral part of a comprehensive emergency medical service. A significant number of resuscitations in our long-term survivors were initiated by bystanders. Improved morbidity and mortality in bystander-resuscitated victims has been documented by Lund and Skulberg⁴⁷ and Donald P. Copley *et al.*⁴⁸ Lay participation in cardiopulmonary resuscitation in Seattle has increased from five to 20 percent over four years in association with a community sponsored cardiopulmonary resuscitation training program.⁴² The American Heart Association has taken a lead in promoting and maintaining national standards of cardiopulmonary resuscitation. All physicians should take an active part in learning and teaching basic life support. Public education in basic life support procedures to sustain life until advanced life support aid arrives is the essential step toward the development of an effective system of comprehensive community emergency medical care.

Patient delay in seeking medical help in cardiac emergencies continues to be a problem. Denial of illness is frequent among coronary patients.⁴⁹ Intensive and appropriate education of the public to recognize the signs of impending or actual cardiac emergencies and to take appropriate action to summon quickly an emergency rescue team, should be undertaken. This may be coupled with instruction in cardiopulmonary resuscitation. "AHA Heart Savers," "Heart Alert,"⁵⁰ and New Jersey State Health Department's "Cardiac Defenders" are a few examples of such programs.

Mobile advanced life support units (MICU) can be operated at a reasonable cost to the community if adapted to existing emergency facilities.

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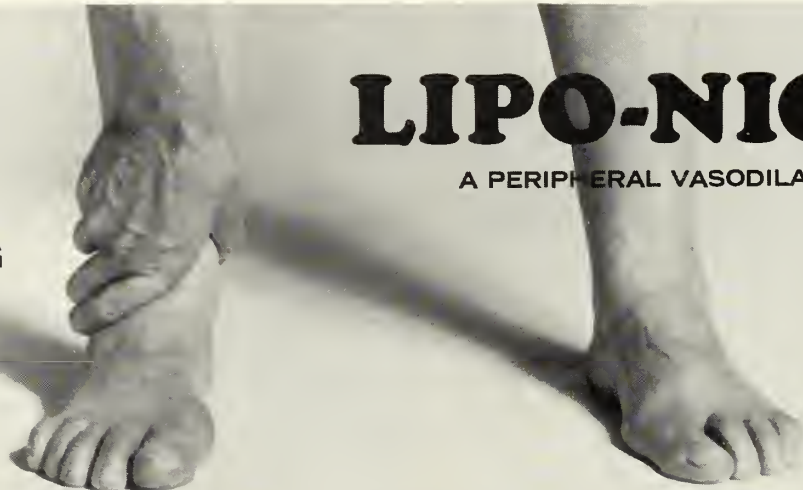
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Evaluation of 99m Tc Pyrophosphate Myocardial Scans in a Community Hospital Setting

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Non-acute PYP scanning allows convenient evaluation of diagnostically difficult cases with present equipment and with a low incidence of equivocal reports. Scans performed nine days after admission retain excellent specificity and predictive value when focal activity greater than two plus (2+) is considered diagnostic of M.I. The sensitivity of this technique is equal to enzymes but less than EKG. The high false-negative rate poses a limitation which theoretically increases with further delay in scanning.

Parisi pointed out that acute myocardial infarct (AMI) does not represent a diagnostic problem in a majority of patients. However, additional objective assessment of myocardial damage may be helpful in patients with chest pain and non-specific EKG or serum enzyme studies, in situations where a clinical history is not available, in patients with pre-existing infarcts, or in patients after cardiac surgery.¹

Since 1974, 99m Tc-pyrophosphate (PYP) has been used to demonstrate acute myocardial infarction in humans. Excellent correlation between PYP scans, serial EKG, and serial enzyme diagnoses have been shown repeatedly.^{2,7} Patients with myocardial infarction (M.I.) usually have positive scans three to seven days after the initial episode.^{2,7} However, positive studies have been reported 20 days after acute transmural infarct.⁴ Bonte, who has performed over 3000 studies, recommends scanning 48 to 72 hours post infarction.⁸

The present investigation was undertaken to determine if myocardial pyrophosphate imaging could be helpful in two medium-size community hospitals when imaging was performed in a non-acute phase of the hospital stay. Scans were performed when it was safe and convenient to send the patient to the department of nuclear medicine without an emergency medical team in immediate attendance.

MATERIALS AND METHODS

We evaluated 88 pyrophosphate myocardial scans per-

formed from January through November, 1976 at the Middlesex General Hospital (MGH) and St. Peter's Medical Center (SPMC) in New Brunswick, New Jersey; comparisons between EKG, enzymes, PYP scans, and final discharge diagnosis were performed retrospectively. PYP scans usually were interpreted by two nuclear medicine physicians. The interpretations were grouped into positive (+), negative (-), or equivocal. Scans with no activity in the myocardium were interpreted as negative. Those with activity less than sternal uptake were interpreted as 1+ or 2+ abnormal. If distinction between myocardial uptake and blood pool could not be made, the scan was interpreted as equivocal. Diffuse 1+ or 2+ myocardial activity was interpreted as insufficient evidence of acute transmural infarction. These cases were considered negative for purposes of this study although the report indicated the possibility that such uptake may be associated with unstable angina or subendocardial infarct. Activity of 3+ or 4+ intensity was considered to represent acute transmural infarction and was considered positive for this study.

EKG diagnosis of AMI was made by one of several

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cardiologists who routinely read in-patient cardiograms. Abnormalities such as "nonspecific changes," "left bundle branch block," or "left ventricular strain pattern," were considered negative or equivocal depending on the wording of the interpretation. Serum enzyme elevations of CPK, LDH, and SGOT were determined simply on a numerical basis in relation to established norms. EKG and serum enzymes were evaluated on the basis of three serial exams performed previous to the PYP myocardial scan.

Patients were scanned in the nuclear medicine department approximately 45 minutes after the injection of 10 to 15 mCi of 99m Tc PYP. Anterior, left anterior oblique (LAO) and left lateral views were obtained. (An additional anterior view of the right chest was obtained for reference.) Scanning time for a typical patient study was about 15 minutes on Nuclear Chicago Pho Gamma HP scintillation camera.

RESULTS

The patient population included 52 males and 36 females, aged 20 to 92 with a mean age of 54. The predominant race was Caucasian; 10 percent were black. The mean body weight was 74 kgm.

Twenty-four patients had a final diagnosis of myocardial infarction (M.I.). Sixty-two patients had a final diagnosis other than M.I. and two patients were equivocal in that the presence or absence of M.I. was left unresolved. In the group of 24 patients who suffered myocardial infarction, 13 had positive scans, 12 had positive enzymes and 12 had false negative EKG and 10 had false negative enzymes. One scan was equivocal; 10 EKGs and two serum enzymes were equivocal. (Table I)

In the group without M.I., 62 out of 62 had negative PYP scans, 38 of 62 had negative EKG and 56 of the 62 had negative enzymes. The false positives in this group were zero for PYP scan, three for EKG and three for enzymes. The scan was equivocal in no instance, while conclusions could not be reached from 21 serial EKG and three serial enzyme studies. (Table I)

The true positive rate for scan was 54 percent which was not significantly greater than that for EKG or enzymes. The false positive rate for scan was zero as compared to four

percent for EKG and four percent for enzymes.

The true negative rate for scan was 100 percent and 90 percent for enzymes. The significantly lower true negative rate of 61 percent for EKG reflected the fact that (21/62) 33 percent of those patients without AMI had equivocal EKG reports. (Table II)

The false negative rate for PYP scans was 41 percent. Enzymes had the same false negative rate. EKG showed eight percent false negatives. (Table II) The sensitivity of scan was 56 percent compared with 85 percent for EKG and 57 percent for serum enzyme. Predictive value of the PYP scan was 100 percent compared to 80 percent for EKG and the same percentage for enzymes. (Table III)

DISCUSSION

We attempted to examine the role that myocardial infarct scanning might play in a community hospital setting. Eighty-eight patients were studied retrospectively; EKG, enzymes, and scans were compared to the final discharge diagnosis. The existing hospital equipment required that the patient be sent to the Nuclear Medicine Department for cardiac scanning and thus studies usually were performed when the patient was stable and in the non-acute phase of his hospital stay.

As might be expected, patients referred for cardiac scans were usually diagnostic problems. Although all of the 24 patients discharged with the diagnosis of myocardial infarction had either elevated enzymes or diagnostic EKG studies in addition to a positive history, only one-third of the patients had both objective criteria. Among the 88 patients evaluated, 35 percent of the EKG studies were equivocal.

The cardiac scan, in retrospect, was an additional helpful objective diagnostic modality. PYP scans were equivocal in only one case out of 88 and demonstrated a specificity and predictive value that was better or equal to values for EKG or enzymes. The sensitivity of the scan was almost exactly the same as that of enzymes, albeit both values were significantly lower than that for EKG. (56 percent 57 percent vs. 85 percent) (Table III)

One of the pitfalls of both the cardiac scan and the enzyme studies was a high false-negative rate of 41 percent as

Table 1
Comparison of Test Results in 88 Patients Evaluated for Myocardial Infarction

Final Diagnosis	Cardiac Scan			EKG			Enzyme		
	Negative	+/-	Positive	Negative	+/-	Positive	Negative	+/-	Positive
Positive 24	10	1	13	2	10	12	10	2	12
Negative 62	62	0	0	38	21	3	56	3	3
Equivocal 2	0	0	2	2	0	0	2	0	0

Table 2
Reliability of Objective Tests for Myocardial Infarction in 88 Patients

		Cardiac Scan		EKG		Enzyme	
True	Positive	13/24	54%	12/24	50%	12/24	50%
True	Negative	62/62	100%	38/62	61%	56/62	90%
False	Positive	0/62	0%	3/62	4%	3/62	4%
False	Negative	10/24	41%	2/24	8%	10/24	41%
Equivocal	Positive*	1/24	4%	10/24	41%	2/24	8%
Equivocal	Negative**	0/64	0%	21/62	33%	3/62	4%

* Those patients who suffered M.I. and had equivocal reports.
** Those patients who did not suffer M.I. and had equivocal reports.

Table 3
*Sensitivity, Specificity and Predictive Value
of PYP as Compared to EKG and Serum Enzyme**

		Scon		EKG		Enzyme	
Sensitivity	True Positive	13/23	56%	12/14	85%	12/22	57%
	True Positive (+) False Negative						
Specificity	True Negative	62/62	100%	38/41	92%	56/59	94%
	True Negative (+) False Positive						
Predictive	True Positive	13/13	100%	12/15	80%	12/15	80%
	True Positive (+) False Positive						

*Two patients not included because of equivocal results.

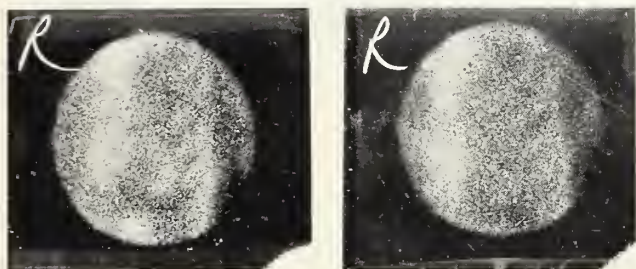


Figure 1A—Shows a PYP scan (ant. view) of a patient who suffered an anterior wall M.I. four days previously. There is 3PYP accumulation in the region of the infarct.

Figure 1B—Shows the same patient (ant. view) seven days after infarction. Note the almost complete resolution of abnormal accumulation.

compared to eight percent for EKG. In theory, the sensitivity of scans would have been higher if they could have been performed earlier in the patient's hospital stay. By comparison, the enzyme studies were drawn on admission and serially thereafter. Since the diagnosis of M.I. usually was not clear-cut in the patients evaluated, the exact onset of the acute disease often was obscured. It is highly likely that a significant number of patients suffered M.I. and sufficient time elapsed before testing to permit return of their enzymes and scans to normal.

Parkey recommends scanning 48 to 72 hours after the onset of suspected clinical infarcts. In this setting, transmural M.I. will show three plus (3+) to four plus (4+) activity 80 percent of the time and two plus (2+) activity 20 percent of the time.⁸ (Figure 1) Some scans may be positive up to three weeks although many revert to normal by seven days.^{4,7}

At St. Peter's Medical Center, the five patients with documented M.I. all had negative scans. The time of scanning ranged between five and eight days after admission. One patient in this group showed "zero activity" but his final diagnosis was actually "subacute" M.I. and the time of onset was placed two weeks before admission. Two other patients in this group had "negative" scans which actually demonstrated diffuse abnormal activity of two plus (2+) intensity. The scan interpretation indicated evidence of myocardial ischemia but insufficient evidence of acute transmural M.I. The remaining three patients had zero to one plus (1+) activity which was felt to be normal or blood pool artifact.

The intensity and timing of PYP accumulation after an infarct appear to depend in part on recirculation to the necrotic area. Bruno has shown in dog experiments that transient coronary occlusions will cause PYP accumulation as early as seven hours later but permanent occlusions required 24 to 48 hours. The intensity of PYP uptake was related directly to the extent of infarction after transient

occlusion but inversely related to infarction after permanent occlusion.⁹

The significance of a negative scan in this study clearly rests on both the time of the scan and the relative activity (0 to 2+) in the region of the myocardium. It has been noted in humans that severe ischemia and subendocardial infarction are associated with a more diffuse and less intense uptake than transmural infarction.^{10,11} (Figure 2) Other investigators warn that the diffuse pattern may be a nonspecific finding related to cardiac blood pool.¹² Classification of two plus scans as "negative" for transmural infarction, with an explanation suggesting the possibility of other less severe cardiac disease, seems to lower the sensitivity for infarction but keeps the specificity high.¹³ (Table III)

The positive scan, i.e., greater than two plus focal activity, has definite clinical significance regardless of time interval. In our study, the false positive rate was zero. Others have reported false positive rates between zero and 40 percent.^{5,14} Originally, the problem of false positives centered around uptake in rib, breast, or blood pool. More recently, it has become a question of distinguishing between severe myocardial ischemia, subendocardial infarct, aneurysm, myocardiopathy, myocarditis, calcified valves, and true transmural infarction.^{5,14} Often, a delayed scan or repeat study in a few days will help establish an evolutionary trend.⁸

SUMMARY

A retrospective examination of 88 patients suspected of having myocardial infarction (M.I.) revealed that non-acute^{99m} Tc-pyrophosphate (PYP) myocardial imaging correlated with the final diagnosis as well as either serial electrocardiograms (EKG) or serial serum enzymes. The mean time of myocardial imaging was nine days after admission. Twenty-four patients had a final diagnosis of acute myocardial infarction (AMI) and of these 13 (54 percent) had positive PYP scans, 12 (50 percent) had positive serum enzymes and 12 (50 percent) had positive EKG studies. False negative scans numbered 10 (41 percent) versus two (eight percent) for EKG and 10 (41 percent) for serum enzymes. The sensitivity of PYP scans was 56 percent which is similar to serum enzymes (57 percent) but less than EKG (85 percent). The PYP scans had 100 percent specificity compared to 94 percent for serum enzymes and 92 percent for EKG. The EKG was equivocal in 31 patients, (36 percent); the enzymes were equivocal in five (six percent) and PYP scans in one patient (one percent).

We conclude that PYP scanning on a non-acute basis using readily available equipment retains sufficient sensitivity and specificity to aid in situations where the presence or absence of M.I. is unclear.

We would like to thank the Mallinckrodt Company for supplying the pharmaceuticals and aiding us with the statistical evaluation.

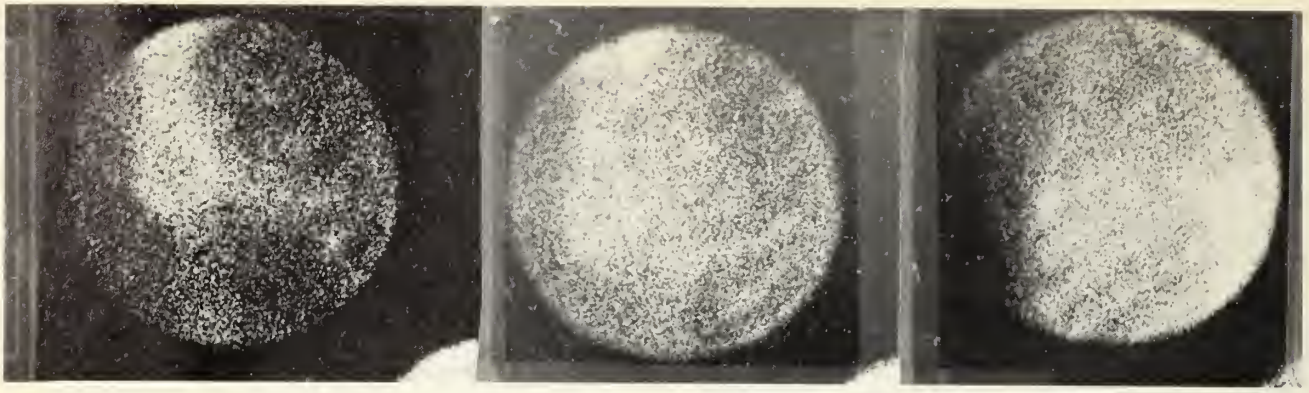


Figure 2—PYP scans, anterior (a), LAO (b) and left lateral (c) views in a patient with diffuse 2+ abnormal accumulation. The patient suffered a subendocardial infarction three days previously.

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Placement of Patients in a Nursing Home

J. A. ROSENKRANTZ, M.D., Newark*

The experience of the Veterans Administration Hospital, East Orange, in placing veterans in a nursing home is reviewed. Of those admitted to the New Jersey Home for Disabled Soldiers 1972-1978, 82.1 percent were 60 years of age or over. Analysis of medical records of 425 patients placed in the New Jersey home revealed that patients most often had a diagnosis classified as chronic neurological, cardiovascular, or complicating medical disorders. Most patients had multiple diagnoses. The discussion emphasizes the need for early planning for patients' discharge from a hospital, an on-staff medical director, and availability of specialists in a nursing home.

Members of the medical staff of hospitals often are reminded to start planning for a patient's discharge on day of admission when the diagnosis warrants long-term care. Which disorders require nursing home care? Which patient diagnoses and disabilities should a nursing home accept and be able to provide high quality care? To find answers, a VA hospital nursing home care program and placements for extended care were reviewed and analyzed.

The Veterans Administration operates nursing home beds within its organization throughout the United States. Because of the unusual demands for nursing home care, additional facilities are provided veterans through contractual relationships with VA approved community and state nursing homes.

The Veterans Administration defines nursing home care as the accommodation of convalescents or other persons, who are not acutely ill and not in need of concentrated hospital care, but who require skilled nursing care and related medical services. For veterans in Nursing Home Care Units of VA hospitals, this includes room, meals, skilled nursing care, physician visits, rehabilitation medical services, emergency dental care, routine medicines and drugs, minimal laboratory or x-ray services and other special services and supplies normally provided patients requiring skilled nursing home care. In general, veterans placed in community or state nursing homes are expected to receive no less.

NURSING HOME STANDARDS

Community nursing homes are approved by the VA if they are accredited by the Joint Commission on Accreditation of Hospitals. The minimum standards required for VA approval are as follows:

1. Licensed or approved by the state in which located and complying with local governmental regulations.
2. One level of care must be provided to include:
 - a. Skilled nursing home care and related medical services.
 - b. Supportive personal care.
 - c. Individual adjustment services including social, diversional, recreational, and spiritual.
3. Care by a duly licensed physician, who shall make routine and emergent visits. He shall also advise on general matters of care and administration and supervision of clinical work.
4. Laboratory, x-ray, and other diagnostic services shall be available on premises or nearby.
5. A medical record must be maintained for each patient to include:
 - a. Admission identification card.
 - b. Form-Referral for Community Nursing Home Care.
 - c. Admitting evaluation and diagnosis.

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- d. Physician orders.
 - e. Progress notes must be maintained chronologically as conditions warrant but not less frequent than once every two months.
 - f. Special reports from laboratory, x-ray, consultations.
 - g. Medications and treatment given.
 6. Nursing service must be under direct supervision of a full time registered professional nurse licensed to practice in the state, who must supervise the overall nursing service; other personnel must be on staff to provide 24 hours a day, seven days a week adequate care.
 7. Medications and narcotics must be stored properly and controlled and issued only on written orders by physicians.
 8. Patients' dietary needs must be in accordance with sound medical practice; records of planned menus shall be kept for one month.
 9. Acceptable safety and sanitation practices must be observed throughout the facility.
 10. Construction:
 - a. Exterior walls of one-story buildings without basements must be constructed either entirely of non-combustible materials or of a combination of materials (exterior surfacing must be non-combustible material) listed by local or State Codes or the National Building Code as having fire resistance rating of at least one hour.
 - b. Exterior walls, stairs, and stair enclosures of buildings of more than one story must be constructed entirely of non-combustible materials.
 - c. A concrete slab must separate all stories and the upper story and attic of buildings of more than one floor level. A basement is considered a separate story.
 - d. Buildings which do not meet the above construction standards may be approved if completely protected by an automatic fire sprinkler system approved by the authority having jurisdiction. In the absence of such an authority, a certificate by the installer that the system protects the entire structure and was designed and installed in accordance with National Fire Protection Association Standard No. 13, Standard for Installation of Sprinkler Systems, may be substituted for such approval.
 11. The facility must provide a cheerful homelike atmosphere with full attention to diversional and social needs. Every effort must be made to keep patients ambulatory.
- Prior to entering into a formal contract with a community nursing home a VA team inspects the premises and if standards are met it may be approved. If a nursing home is found deficient, a reinspection may be scheduled when corrections are made; if the changes are acceptable a contract may be signed. Every effort is made to secure contracts which specify the per diem rate, the cost of routine medical care, drugs, laboratory, x-ray and other necessary services described in the contract, which are in addition to room, meals, and nursing care. In exceptional cases, where this is not possible, the contract specifies those services and supplies which are not included in the per diem rate.
- The team at VA Hospital, East Orange, which conducts inspections, consists of a physician, nurse, dietitian, social worker, a representative of medical administration and a member of the engineering service.

VA PROCEDURES

The following VA procedures govern the selection and movement of patients to nursing homes:

1. Patients are selected at ward level by the physician, nurse, social worker, or a team for placement in community

nursing subject to the approval by the chief of staff of the hospital.

2. Listings of approved local nursing homes are maintained by each VA hospital; where possible, depending on availability of beds, the patient may select the nursing home in which he will be placed.

3. When the patient is approved by the chief of staff, the chief of medical administration service or his designee contacts the nursing home for availability of a bed. On occasions this will have been accomplished by the social work service.

4. VA Form 10-1204, Referral for Community Nursing Home Care is prepared in triplicate with information supplied by the physician, nurse, dietitian, social worker, and other staff members. The original is forwarded to the nursing home in advance of arrival of patient; one copy is attached to the medical record and one copy is for follow-up.

5. Planning for patient's discharge is initiated early to assure that needed dental care, prostheses, or similar appliances are furnished prior to transfer of the patient.

Planning and follow-up are essential. Professional nurses with public health experience also participate as follows:

1. Develop a nursing care plan, prior to the patient's release from the hospital, that may be used by nursing home personnel to provide continuity of services.

2. Make follow-up visits to the veteran after his admission to the community nursing home to insure that adequate and safe care is being provided.

3. Advise community nursing home staffs, when indicated, on specific nursing care skills required by the patient.

4. Make plans for continuity of required nursing care following termination of community nursing home care.

Prior to the patient's release from the hospital, a social worker actively assists patient and family in planning to assume responsibility for future needs following community nursing home care. Various VA and other benefits are fully explored and explained to the veteran and his family. Appropriate assistance is available from the Veterans Service Division, when necessary.

If possible, patients are visited by a VA hospital representative no less frequently than every 60 days. He reviews the patient's file before calling upon the patient. Observations are made on the quality of professional care and the need for continuation of nursing home care. Recommendations are submitted to the hospital having follow-up responsibility, for further investigation and action.

Patients remaining in the community nursing homes for an extended period (more than one year) are given a comprehensive physical examination no less often than once a year to determine the need for continued nursing home care. The report of the examination is reviewed by the placing hospital to determine whether continued care should be approved. A copy of the report of examination is furnished the community nursing home for inclusion in the patient's record.

VA patients in nursing homes have the privilege of readmission to VA hospitals unless this is not feasible because of distance or urgency. If non-emergency rehospitalization is required or the veteran begins to require more than occasional visits by physicians or more than minimal supportive diagnostic studies, readmission to VA hospital is accomplished promptly.

RESULTS

In the period 1972 to 1978, VA Hospital, East Orange

approved placement of 425 male patients in a State nursing home. The age distribution of these patients appears in Table 1.

Table 1
Referrals to New Jersey Home for Disabled Soldiers
1972-1978: Age Distribution

Age	Number	Per Cent
30-39	4	0.94
40-49	16	3.76
50-59	56	13.18
60-69	88	20.71
70-79	114	26.82
80-89	139	32.71
90-99	8	1.88
	425	100.00

The above figures reveal that 82.1 percent of veterans placed in the State home were 60 years or over; 34.6 percent were 80 years or older.

These figures reveal that 82.1 percent of veterans placed in the State home were 60 years or over; 34.6 percent were 80 years or older.

Table 2 lists the various referral diagnoses to New Jersey Home for Disabled Soldiers.

Neurological disorders comprised the most common purpose for admission; cerebral arteriosclerosis and/or organic brain disease and strokes were most prevalent. The next most frequent placement category was cardiovascular disease with arteriosclerotic heart disease, hypertension, and generalized arteriosclerosis predominant. Third in the list were medical disorders. Here, diabetes, chronic obstructive pulmonary disease, alcoholism, and peripheral vascular disease were most common. Post-surgical and orthopedic condition were fourth and fifth in frequency reported on the final summaries. In lesser numbers, psychiatric, urologic, ophthalmologic, malignant, dermatologic, and otolaryngologic conditions, in descending order, also were recorded.

Practically all patients admitted to the nursing home in this study had multiple diagnoses and it can be presumed that many minor conditions were not listed. Table 2 does not stipulate the primary diagnosis. It should be stressed that a primary diagnosis alone does not always require nursing home service. The composite pathologic state may tilt the balance toward admission to a nursing home.

DISCUSSION

From the age distribution and diagnoses of patients admitted to a nursing home it becomes apparent that physicians must become concerned with the aged and their chronic diseases for long-term care. Physicians shy away from caring for the aged partly because their medical school education did not emphasize diseases of the aged and partly because physicians maintain that end results are not productive or that the disorders of the elderly remain static. There is much that can be done to improve function and relieve pain. Making medical rounds in a geriatric setting need not be confined to cathartics and sedatives. Patients who remain for long periods in a nursing home do develop new diseases. The aged are prone to severe infections and it is not uncommon to find cases of pneumonia and tuber-

culosis. Diseases of the liver, pancreas, and gastrointestinal tract make their appearance under the watchful eye of physicians. Further, prescribing medications for the aged is a special art. Dosage must be titrated carefully for each individual patient often at much lower levels than indicated for younger patients. The elderly have altered metabolism, absorption, excretion, end-organ response, or diminished protein-binding of pharmaceutical agents. It is evident that as we become a nation of greater numbers of older people, it becomes necessary for the medical profession to place greater emphasis on the care of the aged in continuing medical education programs.

To ensure high-quality medical care, a medical director should be in charge of a long-term facility to coordinate the services supplied by professional and paramedical personnel. A medical director can serve as an intermediary working in close relationship with staff physicians, establishing policies for medical care, involving himself in quality assurance, implementing and enforcing rules and regulations, establishing emergency procedures, relating to community hospitals, and in working closely with all other services in the long-term facility. He must attract qualified physicians for general and specialized care, particularly, in those fields devoted to the common conditions warranting admission to a nursing home. He should stimulate patient education by physicians, nurses, dietitians, social workers, and rehabilitation technicians.

Planning for discharge of a patient with a diagnosis which may require nursing home care should commence on the day of admission to a hospital. Early involvement will save hospital days and allow sufficient time to make appropriate decisions. Evaluation of the total patient's requirements, discussions with the family, and exploration of the home environment will determine the need to admit to a nursing home.

Certain patients present personal problems which necessitate use of nursing homes. Home care may not be feasible. The patient's spouse may be deceased, too old or feeble, or be employed. Children may be unable to cope with the many needs of the debilitated patient. Often children may be married and concerned with their own family problems or live in cramped quarters making it impossible to bring the sick parent into the household.

The cost of care of the patient with chronic disorders in a nursing home is much less than in a community hospital. There is a real need for nursing homes in the health care delivery system. Additional construction will be required in the future. Existing substandard facilities must be upgraded or phased out. Very few medical centers have nursing-home-care beds. Hospitals are averse to entering this field and prefer contractual affiliations. To become a vital element in progressive medical care nursing homes must discard custodial care practices and become involved in total extended care to provide optimum health care.

This study demonstrates that the aged require greater usage of nursing homes. Patients with chronic neurological, cardiovascular, and complicating medical disorders are likely to require nursing home care. Most of the aged sick have multiple disabling diseases. To meet their needs the whole person must be considered and appropriate services made available at a long-term care facility.

Table 2
Referrals to New Jersey Home for Disabled Soldiers 1972-1978:
Admission Diagnoses

<u>Neurological (77.4%)</u>	
Cerebral arteriosclerosis and/or organic brain disease	125
Stroke-cerebral artery thrombosis or hemorrhage	107
Parkinson syndrome	23
Epilepsy, seizures or convulsive disorders	17
Peripheral neuropathy	16
Multiple sclerosis	10
Hydrocephalus	4
Paraplegia, triplegia or quadriplegia	4
Brain trauma	3
Progressive degenerative central nervous system disease	3
Amyotrophic lateral sclerosis	2
Pseudobulbar palsy	2
Huntington's disease	2
Wernicke's encephalopathy	2
Brain infarct	2
Spinal cord contusion	1
Loss of balance	1
Hepatic encephalopathy	1
Arachnoiditis	1
Hypophyseal coma	1
Basilar artery insufficiency with microemboli	1
Middle cerebral artery aneurysm	1
	<u>329</u>
<u>Cardiovascular (57.2%)</u>	
Arteriosclerotic heart disease	95
Hypertension	52
Generalized arteriosclerosis	44
Atrial fibrillation	12
Congestive heart failure	11
Postmyocardial infarction	10
Hypertensive cardiovascular disease	6
Coronary artery disease and insufficiency	5
Heart block	3
Myocarditis	1
Subacute bacterial endocarditis	1
Supraventricular tachycardia	1
Cardiomegaly	1
Cor pulmonale	1
	<u>243</u>
<u>Medical 53.7%</u>	
Diabetes	53
Chronic obstructive pulmonary disease	46
Chronic alcoholism	26
Arteriosclerosis obliterans	18
Malnutrition, dehydration, or debility	10
Cirrhosis of liver	9
Gastric or duodenal ulcer	8
Pulmonary tuberculosis-active and inactive	7
Rheumatoid arthritis	6
Anemia	6
Gout	5
Tracheobronchitis	4
Chronic renal disease	4
Gastrointestinal hemorrhage	3
Asthma	3
Cholecystitis, cholelithiasis	2
Gouty arthritis	2
Pulmonary emboli	2
Irritable bowel	2
Obesity	2
Psoriatic arthritis	2
Leukemia	1
Subphrenic abscess	1
Metabolic disease	1
Bacteremia	1
Polymyositis	1
Drug dependency	1
Melena	1
Gastritis	1
	<u>228</u>

Surgical and Post-Surgical Diagnoses (21.4%)

Cellulitis, gangrene, ulcer or edema lower extremity	14
Inguinal hernia	13
Hiatus hernia	9
Prostatectomy	9
Diverticulosis — colon or small intestine	7
Insertion of pacemaker	4
Decubitus ulcer	4
Varicose veins	4
Venous thrombosis or thrombophlebitis	3
Fixation fracture hip	2
Colectomy or ileocolostomy	2
Mastectomy	2
Tharacoplasty	1
Gastrojejunostomy	1
Orchidectomy	1
Subtotal gastrectomy	1
Thyroidectomy	1
Postcaval shunt	1
Rectal polyp	

Surgical and Post-Surgical Diagnoses

Clipping middle cerebral artery	1
Ventricular-atrial shunt	1
Cystotomy	1
Ventriculo-peritoneal shunt	1
Aortic valve replacement	1
Rectal abscess	1
Lumbar sympathectomy	1
Fracture skull	1
Rhizotomy	1
Small bowel obstruction	1
Small bowel resection	1
	<hr/> 91

Orthopedics (19.5%)

Osteoarthritis	33
Amputations	20
Fractures	17
Paget's disease of bone	3
Ankylosis and/or arthritis of knee	2
Herniated nucleus pulposus	1
Calcified tendinitis	1
Contracture upper arm	1
Skeletal injuries	1
Osteoporosis	1
Arthropathy of elbow	1
Cervical spondylitis	1
Aseptic necrosis of hip	1
	<hr/> 83

Psychiatric (15.1%)

Senility and dementia	30
Psychotic episodes	11
Reactive depression	8
Schizophrenia	6
Confusion and disorientation	5
Mental deficiency	2
Sociopathic personality	1
Anxiety	1
	<hr/> 64

Urologic (10.1%)

Benign hypertrophy prostate	15
Cystitis	9
Urinary tract infection	7
Urethral stricture	4
Neurogenic bladder	2
Incontinence	2
Kidney calculus	1
Obstructive uropathy	1
Epididymitis	1
Renal cyst	1
	<hr/> 43

<u>Ophthalmologic (7.5%)</u>	
Cataract	19
Blind or poor vision	6
Glaucoma	2
Optic atrophy	1
Macular degeneration	1
Corneal pathology	1
Retinal degeneration	1
Retinitis	1
	<u>32</u>
<u>Malignancy (6.4%)</u>	
Prostate	7
Colon	4
Skin	3
Breast	2
Brain	2
Stomach	2
Lung	1
Bladder	1
Thyroid	1
Tongue	1
Soft palate	1
Floor of mouth	1
Vocal cord	1
	<u>27</u>
<u>Dermatologic (2.4%)</u>	
Syphilis	3
Psoriasis	3
Generalized pyoderma	1
Chronic dermatophytosis	1
Dermatitis	1
Infected sebaceous cyst	1
	<u>10</u>
<u>Otolaryngologic (1.6%)</u>	
Deafness	6
Nasal polyps	1
	<u>7</u>

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CASE REPORTS

Salmonella Infection Complicating Bronchoalveolar Carcinoma

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RAJ B. DHAKHWA, M.D.

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The association of salmonella infections with a variety of malignant disorders is well recognized. The purpose of this report is to document such an infection in a patient with bronchoalveolar carcinoma. Also emphasized is the chronicity of the infection and the difficulty in culturing salmonella species from nonpulmonary tissue. This appears to be the first such report.

The frequent association of salmonella infection with malignant disorders is well recognized. This report documents such an infection in a patient with bronchoalveolar carcinoma and emphasizes the difficulty in isolating the organism from non-pulmonary tissue.

CASE REPORT

A 72-year-old male was admitted to Saint Michael's Medical Center with a three-day history of purulent yellow sputum, cough, and fever. Six weeks prior to this hospital visit he was seen by his private physician in New Hampshire for routine evaluation pending immigration. At that time a positive tine test was noted and a chest x-ray demonstrated a left lower lobe infiltrate associated with calcified granuloma and right apical thickening. Because of the infiltrate he was treated with tetracycline and asked to return.

The patient was a chronic, two-pack-a-day cigarette smoker for over fifty years. He had pneumonia one year ago and was treated with antibiotics. He denied any previous history of tuberculosis, hemoptysis, or occupational exposure. At the physical examination he was in no acute distress. He was afebrile with a pulse of 120 and a respiratory rate of 18. There was no adenopathy. Examination of the chest demonstrated dullness to percussion and bronchial breath sounds with crepitant rales over the entire left hemithorax. There was no cyanosis or clubbing.

Laboratory data: White blood count was 23,000 with 80

percent polymorphonuclear cells. Urine analysis, smears for tuberculosis, BUN, glucose, and an electrocardiogram were within normal limits. A radiograph of the chest demonstrated left lower lobe air space consolidation associated with air bronchograms (Figure 1). Sputum cytologies were negative and multiple bacterial studies demonstrated normal flora. PPD 5 tu was 45 millimeters indurated.

After treatment with penicillin there was no improvement on radiographic examination of the chest. Because of his markedly positive PPD skin test and persistent infiltrate, a therapeutic trial with isoniazid and ethambutol was begun. When the chest infiltration failed to resolve, fiberoptic bronchoscopy and transbronchial biopsy were performed; these demonstrated purulent secretions emanating from the superior segment of the left lower lobe. There was marked bronchial inflammation and narrowing but no evidence of endobronchial obstruction. A bronchial biopsy showed inflammatory bronchial changes. Culture of secretions aspirated from the superior segment of the left lower lobe yielded normal flora.

Antituberculous therapy was continued but repeat x-ray three months later demonstrated persistence of the left lower lobe infiltrate. He was readmitted to Saint Michael's Medical Center because of episodes of fever, shaking chills, cough, leukocytosis, and a progression of his left lower lobe

*This report is from the Saint Michael's Medical Center in Newark, where Dr. Safirstein is Director of Pulmonary Medicine.



Figure 1—Chest radiograph demonstrating left lower lobe consolidation.

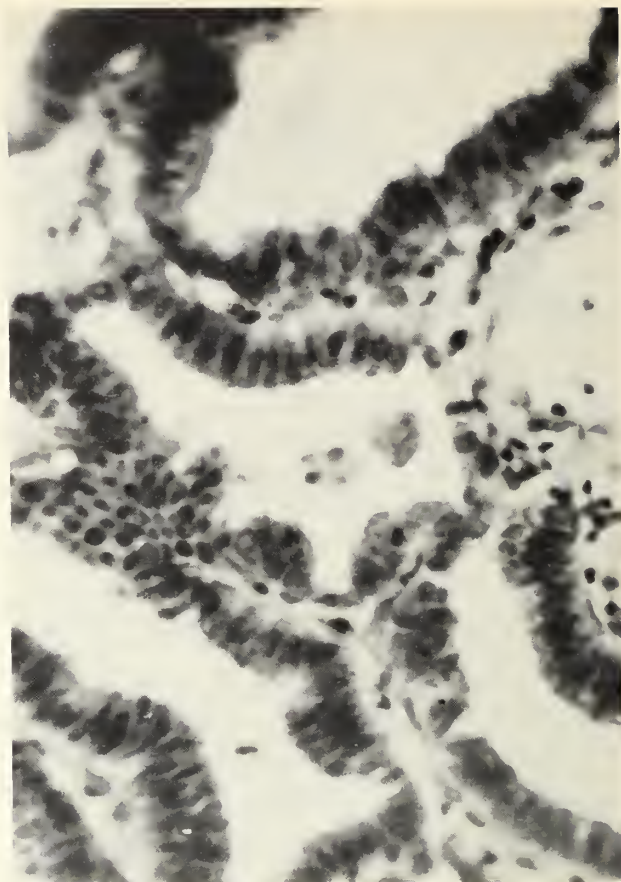


Figure 2—Lung biopsy demonstrating alveolar carcinoma.

infiltrate. Blood, urine, and sputum cultures again were unremarkable. Cultures for tuberculosis taken previously were negative. Antituberculous therapy was discontinued. Because of the persistent infiltrate and the absence of significant cultures, he underwent a second fiberoptic bronchoscopy with findings no different from the earlier examination. In view of those inconclusive findings an open thoracotomy with lung biopsy was performed. Histopathological findings revealed alveolar cell carcinoma (Figure 2). Cultures of lung tissue grew *Salmonella enteritidis* Group C₂, sensitive to ampicillin, tetracycline, and chloramphenicol. Ampicillin in dose of 500 mg four times a day was started and the fever and symptoms abated.

The patient remained on ampicillin therapy after discharge to be followed in clinic. After four weeks of antibiotic therapy, ampicillin was discontinued. The patient had recurrence of fever and cough which promptly remitted when ampicillin was restarted. Over the following twelve months there was a deterioration with weight loss, bronchorrhea, increasing shortness of breath, progressive bilateral pulmonary infiltrates, and declining pulmonary function. On his final hospital admission two years following his initial one, he died of respiratory failure with extensive bilateral pulmonary infiltrates, which on autopsy confirmed the presence of widespread alveolar cell carcinoma. Cultures of lung tissue obtained at post mortem were sterile.

DISCUSSION

The purpose of this case report is to document the rare association of alveolar cell carcinoma with secondary

salmonella infection. In addition, the report also underlines the difficulty in isolating salmonella organisms from blood, sputum, and bronchoscopic washings despite clinical infection. Salmonella infection associated with malignant processes such as leukemias and lymphomas is well recognized. In most instances, *Salmonella typhimurium* has been the infecting organism. Salmonellosis also was reported occurring in patients with carcinoma of the colon, rectum, and bladder, uterus, and ovaries; more than 50 percent of the cases were associated with salmonella septicemia.^{2,4} In a majority of cases *Salmonella typhimurium* and *Salmonella darby* accounted for the invading organisms. In most cases of salmonella infection, predisposing factors in patients with malignancy have included chemotherapy, corticosteroid therapy, irradiation, and previous abdominal surgery. Focal pulmonary salmonellosis is a distinct clinical rarity. Weiss *et al.* reported four cases of salmonella lung abscess associated with pleural effusion, empyema, and pneumonia.⁵ Han *et al.* reported salmonella infection of the pleural space in the absence of carcinoma.³ To our knowledge there have been no reported cases of salmonella complicating bronchoalveolar carcinoma.

Isolation of salmonella organisms has been difficult in most instances of pulmonary salmonellosis.⁶ The diagnosis in the majority was established following open lung biopsy or at autopsy. Davidson *et al.* concluded that open lung biopsy proved to be the only definitive means of establishing pulmonary salmonellosis and that sputum, urine, stool, and blood cultures were not reliable.⁷

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Ectopic Production of ACTH by a Primary Adenocarcinoma of the Colon*

JOHN E. STAMBAUGH, JR., M.D., Ph.D., Cherry Hill, and
ERNEST S. REDFIELD, M.D., Woodbury

Ectopic ACTH production resulted in severe, refractory hypokalemic alkalosis, weakness, and diabetes mellitus in a patient undergoing treatment for adenocarcinoma of the colon with hepatic metastasis. Autopsy findings demonstrated carcinomatosis with markedly elevated levels of ACTH in the tumor by radioimmunoassay. Most cases of ectopic ACTH production by tumors involve pulmonary, thymic, and pancreatic tumors. This case is believed to be the first reported adenocarcinoma of the colon causing the ectopic ACTH syndrome.

Adrenocorticotrophic hormone (ACTH) production by nonpituitary tumors has been described in over 300 examples of the ectopic ACTH syndrome as described by Meader *et al.*¹ Malignant tumors of the lung, thymus, and pancreas have been associated primarily with the ectopic ACTH syndrome but uncommon tumors involving the esophagus, stomach, larynx, salivary glands, and pancreas also have been discussed.²⁻⁴ In the present report we describe a patient with an adenocarcinoma of the colon with hepatic metastasis responsible for the production of the ectopic ACTH syndrome.

Case Report—A 72-year-old male was admitted to Underwood-Memorial Hospital with severe chest pain which subsequently was found on x-ray to be due to pathologic fractures of the ribs. A bone scan demonstrated multiple sites of metastatic disease and a barium enema demonstrated a primary lesion in the right colon. A palliative resection of the primary lesion was performed (Figure 1) and liver and bone metastases were confirmed by biopsy. The patient was improved postoperatively and a course of chemotherapy with fluorouracil was instituted. Studies for other metastases, including a brain scan and skull series, were negative. The serum electrolytes were normal.

The patient was improved and tolerated treatment well for a period of ten weeks. Two weeks prior to readmission he developed increasing generalized weakness which progressed to the point that he became bedridden and unable to lift his head. In addition, over several days, he developed

severe diarrhea with clay-colored stools, icterus, and rapid hepatic enlargement. Because of his rapid deterioration the patient was rehospitalized. Liver function studies demonstrated early hepatic failure with a total bilirubin of 5.7 mg/dl and a 4.1 mg/dl percent direct fraction. In addition, marked serum hypokalemia of 1.6 meq/l (normal 3.5-5.0 meq/l) was noted; the other serum electrolytes were: sodium, 156 meq/l (normal 125-145 meq/l), chlorides 87 meq/l (normal 95-105 meq/l), CO₂ concentration 52 meq/l (normal 24-32) and serum glucose 332 mg/dl percent (normal 65-110 mg/dl). Despite fluid supplements, electrolyte replacements and insulin therapy, serum electrolytes and glucose levels did not change significantly.

Because of the profound weakness and hypokalemia, ectopic ACTH production by tumor was suspected. Serum ACTH levels were increased to 185 pg/ml (normal 10-80 pg/ml) and serum 17-hydroxycorticosteroid levels were increased to 28.2 mg/day (normal 5-22 mg/day). Dexamethasone suppression was performed without any suppression of corticosteroid levels. Further evaluation and treatment were of no value; the patient developed progressive hepatic failure, renal failure, broncho-pneumonia and died.

An autopsy demonstrated diffuse intra-abdominal metastases with poorly differentiated adenocarcinoma in the

*This report is from the Underwood-Memorial Hospital, Woodbury, New Jersey. Dr. Stambaugh may be addressed at 1210 Brace Road, Cherry Hill 08034.

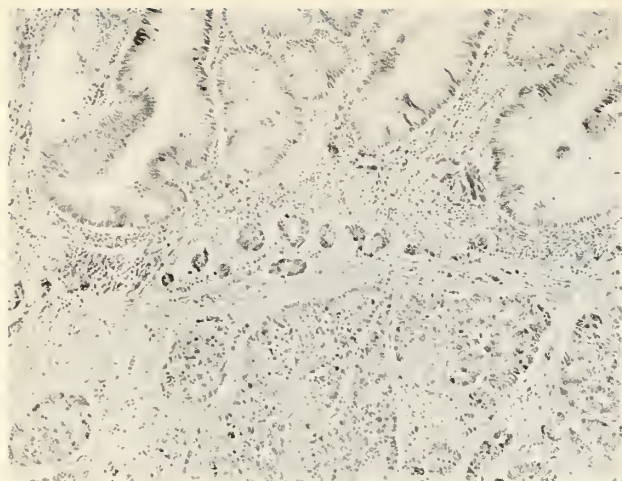


Figure 1 (X75)—Surgical specimen. Relatively normal colonic mucosa (upper half) merging with poorly differentiated infiltrating adenocarcinoma (lower half).

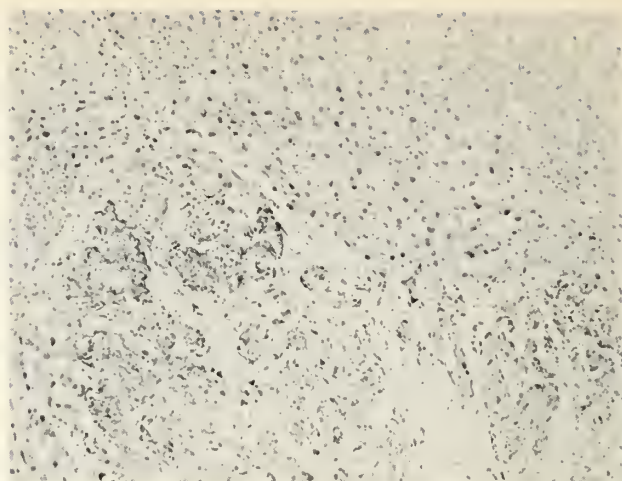


Figure 2 (X75)—Autopsy specimen. Slightly inflamed and degenerated hepatic parenchyma (right upper half) with metastatic poorly differentiated adenocarcinoma (left lower half).

liver (Figure 2). Comparison of the liver metastasis to the surgical specimen (Figure 1) showed that the two tumors were identical. The ACTH level by radioimmunoassay in the tumor tissue was 2350 picograms/gm of wet weight. The ACTH level in a control human liver was less than 40 picograms/gm of wet weight and the ACTH level in a human hepatoma was less than 40 picograms/gm of wet weight. In addition to the abdominal carcinomatosis, the patient was found to have multiple bony metastases. There was no evidence of cerebral abnormality, but terminal bronchopneumonia was noted.

The diagnosis of ectopic ACTH syndrome was suggested by the sudden, otherwise unexplained development of severe hypokalemic alkalosis, profound weakness, and diabetes mellitus. It was confirmed by the finding of high serum and tumor levels of ACTH.⁴ The concentrates of ACTH were measured directly by radioimmunoassay and the concentration is similar to that reported by Ratcliffe *et al.*⁵

SUMMARY

Ectopic production of ACTH from pulmonary, thymic, and pancreatic tumors comprises greater than 85 percent of the reported cases of this syndrome. Other tumors have been

described as causing the ectopic ACTH syndrome including gastric carcinoma, but no cases of primary colon carcinoma have been reported to our knowledge. This case is believed to be the first documented instance of a metastatic adenocarcinoma of the colon producing the ectopic ACTH syndrome.

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Superficial Basal Cell Carcinoma of 32 Years' Duration

PHILIP LoBUONO, M.D., Long Branch
JACK ALBERT, M.D., New York City

Superficial basal cell carcinoma is characterized by its chronicity and lack of local invasion. This report describes a case of 32 years' duration which was repeatedly misdiagnosed as eczema.

Basal cell carcinoma is the most common malignancy affecting the skin of the white population. This tumor originates from the neoplastic development of basal cells of the surface epidermis or external root sheath of the hair follicle. There are several clinical forms of basal cell carcinoma, the nodulo-ulcerative type being the most common. Most often found on the face, it usually presents as a slowly enlarging papule which eventually shows central ulceration. If allowed to persist, the process is one of slow but continuous enlargement and destruction of tissue due to local invasion. In extreme cases, death can ensue from involvement of underlying vital structures.¹

One clinical variant of this tumor, the superficial basal cell carcinoma, is noted for its chronicity and lack of invasion. We present a case of superficial basal cell carcinoma of 32 years' duration; it was an incidental finding in an elderly female hospitalized for an unrelated problem.

CASE REPORT

The patient is a 72-year-old female admitted to the hospital for a fracture of the head of the right femur. During the initial physical examination a "patch of eczema" was noted on her left lower abdomen. On questioning she reported that the lesion first appeared in 1946, was the size of a nickel, and slowly has enlarged over the years to its present size.

Three different physicians made the diagnosis of eczema during the years of its growth. She denied any symptoms or

bleeding associated with the lesion. This tumor was a slightly elevated, irregular plaque, approximately three cm in diameter. There was scaling, mild erythema, and a sharply defined, slightly rolled border, but no ulceration. (Figure 1). A biopsy was taken. Extending focally from the flattened epidermis into the superficial portion of the cutis there were anastomosing nests of small, dark-staining epithelial cells focally showing palisading at their margins (Figure 2). The histology was consistent with the diagnosis of a superficial basal cell carcinoma. The lesion was treated topically with 5 percent fluoro-uracil cream.

COMMENT

Superficial spreading basal cell carcinoma differs clinically from the other types of basal cell carcinoma. It usually is found on the trunk of affected individuals, rarely invades underlying structures and is noted for its chronicity.² Our patient's tumor displays all three characteristics. These morphological variations can cause confusion as to the correct diagnosis when viewed by unwary examining physicians. This is illustrated by the fact that on three different occasions her skin tumor was diagnosed as eczema.

The extended life of this carcinoma is also of note. The

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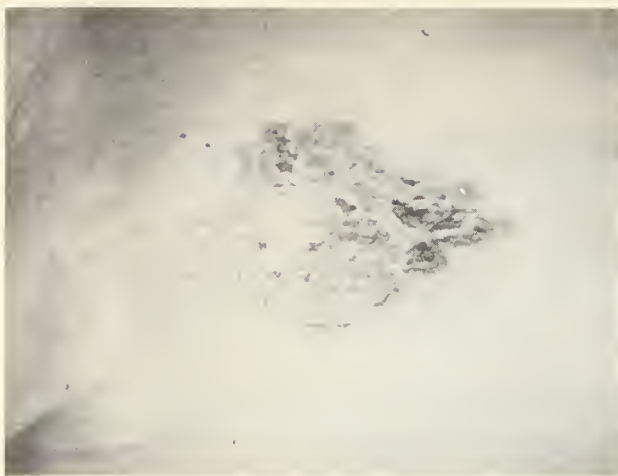


Figure 1—Scaling, slightly elevated lesion with well-defined, slightly rolled border.

major textbooks of dermatology only make passing mention of this characteristic longevity.^{1,2,3} A review of the recent dermatologic literature failed to reveal any reports on this subject. These tumors, if left untreated, can persist for decades. Superficial basal cell carcinoma should be part of the differential diagnosis of long-lasting, non-resolving lesions of the trunk and extremities.

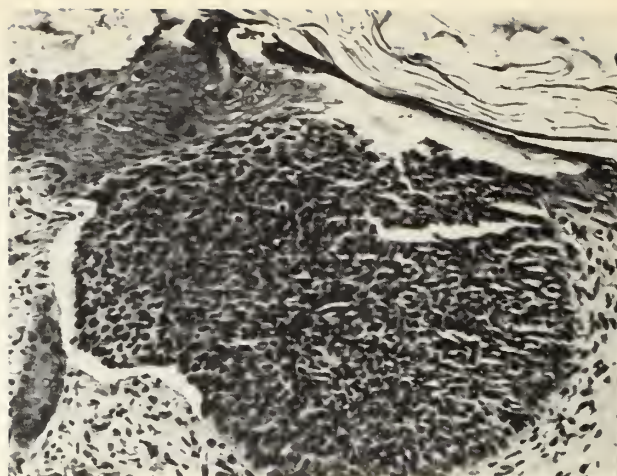
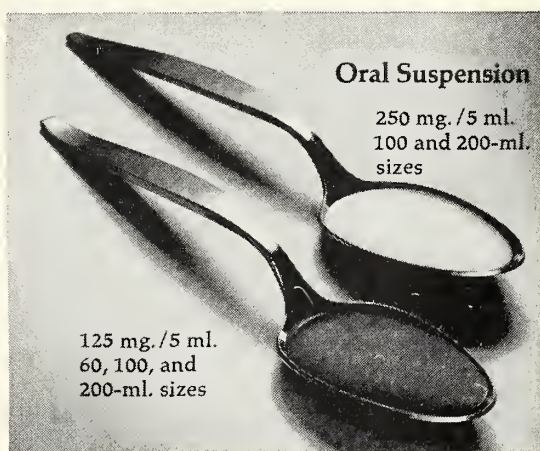
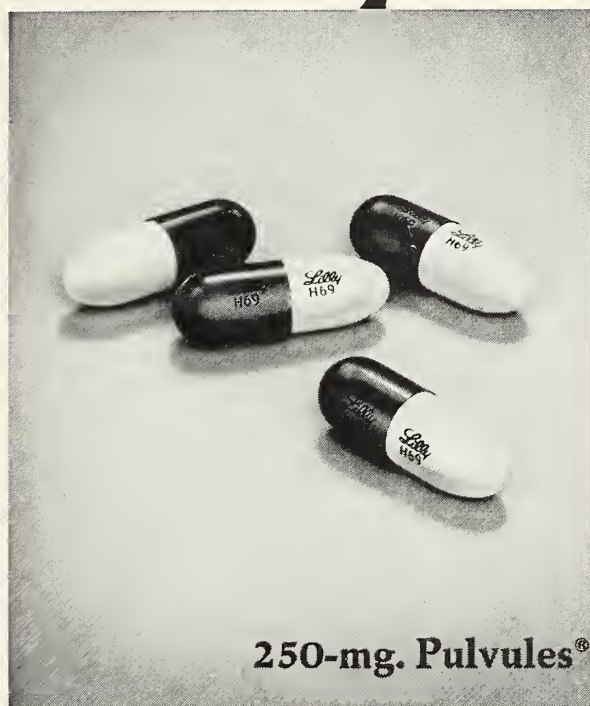


Figure 2—Nest of basaloid cells showing hyperchromatic nuclei, retraction spaces, and palisading at the margins.

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A Guide to Contraceptive Advice

JEROME ABRAMS, M.D., North Plainfield*

A brief, practical guide is offered to family physicians so that they more easily may provide their patients with contraceptive advice while avoiding the pitfalls so potentially serious in today's litigious society. Current methods of contraception, their more common side effects, and their contraindications are presented without discussing pharmacology and technique.

Family physicians and internists are confronted with questions about and requests for contraception with almost the same frequency as obstetricians and gynecologists. Consequently it is incumbent upon them to be fairly conversant with the current methods of contraception as well as knowledgeable about contraindications and side effects.

A guide is presented here to family physicians and internists so that they easily and promptly may render their patients the best contraceptive advice while avoiding the pitfalls so common and so potentially serious in today's litigious society. No attempt will be made to discuss the patho-physiology and pharmacology of contraception or to describe all brands of oral contraceptives, all mechanical devices, and all possible side effects but merely to offer a practical method of dealing promptly with 90 percent of patients seeking contraceptive advice.

ORAL CONTRACEPTION

The immense popularity of oral contraceptives (OCs) during the past ten years is explained by the fact that they are nearly 100 percent effective, and allow regular, painless, menses for the vast majority of patients.¹ Below the age of thirty, OCs cause few or no significant side effects. Breast cancer, vascular disease, liver disease (either known, suspected, or historical) and possible pregnancy represent absolute contraindications.^{2,3,4} There are a host of other conditions: e.g., diabetes mellitus, migraine syndrome, hy-

pertension, and oligomenorrhea that represent relative contraindications depending upon their severity, the age of the patient, the degree of obesity, and concomitant use of tobacco.^{2,3,5} Since OCs cause decreased glucose tolerance and increased fluid retention, any condition aggravated by these phenomena will require more frequent monitoring, especially in patients over age thirty.⁶ Determinations of blood pressure and weight, urinalyses for protein and glucose, examinations of the breasts and veins of the lower extremities should be included. Many signs and symptoms respond to salt and/or caloric restriction, diuretics, elevation of the legs, and support hose.

The gynecologist who prescribes OCs may be astounded to learn that his patient has gone elsewhere for metabolic screening and even breast biopsy while still taking contraceptive medication.³ A period of hospitalization and/or brief consortial separation represent excellent opportunities (often missed) for a one-cycle respite from the almost daily bombardment of the anterior pituitary by the OCs' synthetic estrogens and progesterones. Should no such specific opportunity present itself, the physician should advise all patients to take a one-cycle break at least every twelve to twenty-four months, particularly if OCs seem to be causing hypomenorrhea or oligomenorrhea. Many patients will experience misgivings, if not anxiety, as hypomenorrhea

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progresses to complete amenorrhea. Consequently it is better and easier to take a one-cycle break sooner than later; otherwise one may have to deal with a "post pill amenorrhea" syndrome lasting several months.^{3,7} Although this syndrome is more of a psychological and social phenomenon than medical, the innumerable telephone calls will prove vexatious and time consuming.

A variety of side effects occasionally occur when OCs have been prescribed: increased skin pigmentation, visual changes, scalp hair loss, nausea, acne, and headaches. The more serious or more annoying signs and symptoms require cessation of OCs and evaluation or re-evaluation, but minor symptoms may be treated with symptomatic medication and/or changing brands. It is advisable initially to gain experience with one particular brand of oral contraceptive drug so that side effects and other signs and symptoms may be evaluated and treated more readily.

It has been recommended that OCs be discontinued for two or three cycles prior to conception for fear of chromosomal changes that might affect the fetus.^{3,8}

BARRIER CONTRACEPTION

Various mechanical devices and chemical compounds have been invented to serve as a barrier between semen and cervical os. Although numerous foams, creams, and recently a suppository have been promoted as effective chemical barriers, their efficacy is far below the condom, diaphragm, and intra-uterine devices (IUDs) and even further below OCs.⁹⁻¹² The physician who recommends any of these compounds exclusively may be blamed by the disgruntled patient for the unwanted, unplanned pregnancy.

Although it seems that one of the freedoms of the women's movement has been the liberation of young men from the condom, many men still can be persuaded to use condoms as an alternative form of contraception during the two or three cycles prior to attempted conception (after discontinuation of OCs) or during the annual or biennial "break" from OCs.^{3,8} It is not at all unusual today to examine patients from all socio-economic and educational levels, who are concerned about venereal disease after contact with a transient partner, sometimes as an aftermath to a domestic quarrel. Thus, the original purpose of the condom as a "prophylactic" agent need not be ignored. A concerned physician may instill enough self-confidence in the patient to say "no" occasionally and not fear that her social and/or professional career will be jeopardized. At least insistence on use of a condom will offer her protection against venereal disease¹³ and/or pregnancy if nothing else.

The contraceptive diaphragm should be considered at the time OCs are prescribed, at a pre-marital visit (or at a pre-marital visit), at a six week post-partum examination, or at almost any time there is a pelvic examination during the reproductive years.¹⁴ Even the most finicky patient who is unable to insert a tampon may appreciate discovering that a diaphragm is a possible alternative. The very few patients who are anatomically unsuited for diaphragm use might just as well become aware of this situation sooner than later. Should the patient prove amenable to a diaphragm, she should be encouraged to gain facility and experience with the device while taking OCs in the event that the pills prove impractical or hazardous. Any physician can be taught to fit a diaphragm by a colleague or a nurse in five minutes after requesting the "detail man" to provide a set of "fitting diaphragms". These are preferred to "fitting rings," which are more difficult to manipulate. Initially the physician

should gain experience with the arcing spring diaphragm rather than with the coil spring or flat spring type.

INTRA-UTERINE DEVICES (IUD)

The IUD is particularly suitable for the multipara who has been delivered of all the children she plans to have but is not yet ready for sterilization. Such patients are usually in their thirties, have had occasional annoying side effects with OCs and/or are unhappy about the prospect of oral contraception for five or more years. The IUD is particularly unsuitable for the nulligravida despite the fact that four companies manufacture specific IUD's for nulligravidas and nulliparas. Physicians may have difficulty resisting the propaganda from these companies and countering the mass media who cater to the national preoccupation for instant gratification and who intimidate young women with the danger of getting fat and/or cancer from OCs. Prescribing physicians should be aware of three unsatisfactory aspects of this adventure:

(1) Insertion of an IUD into a uterus that has never been significantly enlarged by pregnancy is frequently difficult for the physician and painful for the patient.¹⁵

(2) The rate of spontaneous expulsion and of requests for IUD removal because of pain and bleeding is much higher with the nulligravida than with the multipara. In such an instance the physician bears the brunt of resentment and disappointment with an unsuccessful and expensive attempt at intra-uterine contraception, not the manufacturer.¹⁶

(3) The unmarried nulligravida who does not expel or request removal of the IUD seems to have a higher pregnancy rate and a greater chance of contracting venereal disease, possibly due to more frequent sexual intercourse with more men. Venereal disease with an IUD *in situ* spreads rapidly and the subsequent pelvic inflammation that leads to sterility represents an infinitely greater tragedy to a nulligravida than to the multipara.¹⁷⁻¹⁹ Prompt removal of the IUD is advisable in the event of pregnancy or pelvic inflammation.^{8, 20-22}

Finally there remains the advisability of intra-uterine contraception for the multipara considering another pregnancy in a few years.^{15,23} The success rate with IUD's is not much more than 75 percent despite the testimonials from the manufacturers.²¹⁻²³ Success will be enhanced by the increased experience and improved technique of the physician as well as by alternative contraception during the first three months after insertion by the well-motivated, experienced multipara. Unless there are specific problems with oral contraception or barrier contraception, these methods should not be abandoned readily for the two or three years between pregnancies.

The "Lippes Loop," which has been used for more years than all other current devices, is the easiest and safest to insert by the less experienced physician. As long as there are no untoward side effects, the loop has the additional advantage that it may be left *in utero* for many more years than the Progestosert® or the copper IUDs which should be removed in one to three years respectively. Any physician quickly can be taught the technique of loop insertion as well as the precautions, contraindications, and possible side effects at any family planning clinic.

STERILIZATION

The ultimate and definitive form of contraception that has grasped the body and soul as well as the imagination of the public is tubal ligation and vas ligation. Today these procedures are available to virtually everyone whether married or single on the basis of a consent form signed by the patient alone. It is hoped that the physician will not accede readily to

the patient's request for sterilization without exploring all possible contingencies that might cause him or her to regret a hasty decision at a later date. With today's traveling and divorcing population there is scarcely a gynecologist or urologist who has not met a young patient seeking to have "tubes untied." Such operations are frequently unsuccessful.

That portion of the public which wants readily available sexual gratification at any time without fear of pregnancy has shown increasing preference for sterilization, once no further pregnancies are planned. This is enhanced by the availability of prophylactic or therapeutic treatment for venereal disease. The age of thirty-five (certainly forty at the latest) has become accepted as the limit beyond which the higher incidence of potential maternal and fetal complications contraindicate pregnancy. Even the IUD, which has been successfully and safely fulfilling its purpose *in utero* for many years, may represent a source of confusion when abnormal uterine bleeding and/or unexplained pelvic pathology occurs after the age of thirty-five or forty. These factors plus the government's injunction against OCs for smokers after the age of thirty-five and for everyone over forty all serve to create the demand for primary sterilization.²⁴⁻²⁷

The most ideal situation exists when both husband and wife comfortably can discuss the pros and cons of female and male sterilization with their primary physician and then request referral to the gynecologist or urologist.

COMMENT: AN OPPORTUNITY

When the medical pioneers were seeking a simple, inexpensive method of contraception that would permit a young couple to limit the size of their family to the number of children they could feed, clothe, and educate, they never envisaged the enormity of the social problem which would result from the fear of unwanted pregnancies. They did not predict the medical problems such as an increasing incidence of venereal disease,²⁸ teen-age pregnancies, and cervical dysplasias undoubtedly associated with earlier and more promiscuous sexual intercourse.^{13,14,29,30} In 1973, 14 percent of our children were raised in fatherless homes; this figure is double that which existed ten years earlier. Subsequent percentages are provided for "single parent homes" instead of fatherless homes now that increasing numbers of women are abandoning their children. The most recent estimate indicates that "one third of all U.S. children will spend a significant amount of time with a divorced or single parent."³¹ With more patients receiving private care for gonorrhea and syphilis with less consistent follow-up, the reality of the venereal disease epidemic is worse than the statistics might indicate.³² The emotional, psychosomatic, and psychoneurotic problems associated with the aforementioned phenomena confront family physicians, internists, pediatricians, and obstetrician-gynecologists with increasing and frustrating frequency.³³

Now that organized religion and the family no longer provide the degree of respect and authority as well as emotional support and comfort they once did, the scientific word that falls from the physician's lips seems to enjoy a greater (though unwarranted) degree of respect and authority and a lesser degree of emotional support and comfort. The physician who provides contraceptive advice today cannot help but occasionally feel like a ticket-seller to this ever-popular orgiastic pastime. However, a unique opportunity is being presented to the physician who examines the young female patient. If he spends a few extra minutes in conversation he has the opportunity to show interest and

concern and to guide the young patient seeking to establish her own identity and individuality, not merely as a sex object but as an integrated, secure, and stable human being.

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Carotid Sinus Massage in Tachyarrhythmias

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Carotid sinus massage (CSM) is a valuable, often neglected, non-invasive technique for establishing a diagnosis of various cardiac arrhythmias. The response to carotid sinus massage is particularly useful in diagnosing and treating tachyarrhythmias, especially those that are regular.

Case #1—A 54-year-old male with rheumatic heart disease and mitral insufficiency was receiving digitalis and diuretic therapy. He was admitted to the Intensive Care Unit in severe congestive heart failure with a ventricular rate of 108 beats/min. The rhythm was regular.

The ECG (Figure 1, top strip) revealed a regular tachycardia at a rate of 108 beats/min. The QRS was wide, 0.13 sec. in duration, P waves were not seen. The differential diagnosis was between a slow ventricular tachycardia and a supraventricular tachycardia with aberrant conduction. It was important in this patient to establish a diagnosis since therapy depended on the mechanism of the tachycardia. Paroxysmal atrial tachycardia or ventricular tachycardia could be due to digitalis intoxication; paroxysmal atrial flutter could require more digitalis.

Carotid sinus massage applied at the beginning of the bottom strip led to A-V block exposing a long run of the typical undulating baseline of atrial flutter. Of additional interest was the normalization of the QRS after the pause. This persisted until the end of the tracing where the rate increased and the aberrant conduction returned. Carotid sinus massage demonstrated that the basic rhythm was atrial

flutter and that the ventricular conduction defect was rate related.

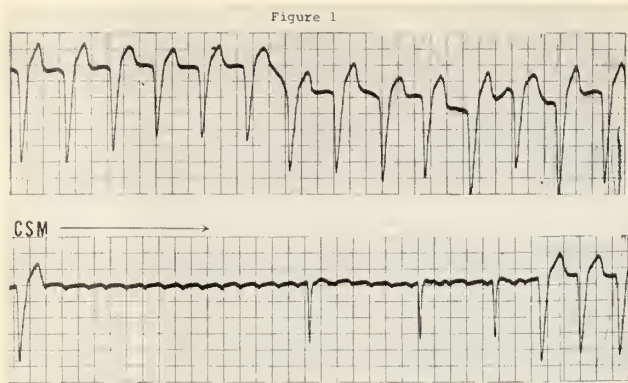
To establish a diagnosis in this case, the alternative to carotid sinus massage would be an invasive procedure: either a His bundle intracardiac catheter, the passage of a wire into the right atrium to sense the atrial activity, or an esophageal lead E.C.G. By these means atrial activity can be determined accurately and the degree and type of A-V conduction delineated. In this case the simpler, more easily performed and less risky maneuver of carotid sinus massage led to the correct diagnosis and proper therapy.

The patient was given additional digitalis, the A-V block increased, the ventricular rate slowed (atrial flutter at 4:1 block) and the congestive heart failure cleared.

Case #2—A 62-year-old female presented with an established diagnosis of alcoholic cardiomyopathy. She was in moderate congestive heart failure and had been receiving digitalis and diuretic therapy. Her apical and radial impulses

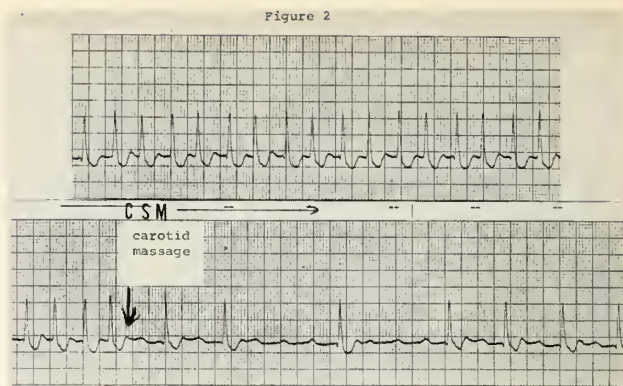
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were regularly irregular at a rate of 166 beats/min. A murmur was not audible, but there was a clear diastolic gallop.

For diagnosis and therapy her right carotid sinus was massaged. The ventricular rate abruptly slowed to 44 beats/min, exposing regular P waves at a rate of 166. Following release of carotid pressure the ventricular rate increased to 84 beats/min. Therefore the initial rhythm (Figure 2—top strip) was paroxysmal atrial tachycardia with irregular block. The block in this case was first degree with alternating duration of the P-R interval. The rhythm at the end of the bottom strip was paroxysmal atrial tachycardia with 2:1 A-V block. Paroxysmal atrial tachycardia not due to digitalis toxicity usually is unaffected by carotid sinus massage or responds by breaking to regular sinus rhythm. Digitalis toxic paroxysmal atrial tachycardia (PAT) with



block responds to CSM by slowing the tachycardia or does not respond at all. In this patient, digitalis was stopped and potassium administered (her serum K^+ was 3.1 mEq) and regular sinus rhythm was restored. Her congestive heart failure cleared with continued diuretic therapy.

SUMMARY

These cases illustrate the usefulness of carotid sinus massage in tachyarrhythmias. The procedure was diagnostic in that the underlying atrial arrhythmia was exposed leading to correct therapy. In other applications, carotid sinus massage may be useful in relieving an episode of angina pectoris and occasionally pulmonary edema. In the analysis of syncope associated with bradyarrhythmia, carotid sinus massage may be diagnostic as it also may be in hypersensitive carotid sinus syndrome.

Food-Borne Disease

EDMUND A. ZOTTOLA, Ph.D., St. Paul, Minnesota

Do you enjoy eating raw hamburger? Do you occasionally taste uncooked, ground meat while preparing a meal? Has this unconscious habit of yours ever resulted in an unexpected illness? If not, you are luckier than several homemakers in the western United States who, as they prepared their family dinner of ground meat, sampled a bite of the raw, ground meat. A few days later, they became ill with severe diarrhea. Some required hospitalization. They had contracted salmonellosis, a type of food-borne disease common in the United States today. Their families ate only the cooked meat and did not become sick as the heat involved in the cooking killed the bacteria that caused the symptoms.¹

How would you like to be on a transcontinental flight for many hours and suddenly have severe stomach cramps, nausea, vomiting and explosive diarrhea with 100 or so fellow passengers? It would not be a very pleasant experience.² Well, it has happened on several occasions. The cause is *Staphylococcus aureus*. This bacteria probably causes more cases of food-borne disease in the United States than any other microorganism.

Many such instances of food-borne disease probably occur each day all over the United States but they may go unrecognized or undiagnosed or passed off as "stomach-flu," a "virus," or "something that's going around." The Center for Disease Control (CDC) in Atlanta, Georgia is the agency responsible for reporting outbreaks of food-borne disease. Their activities depend upon reporting agencies in the 50 states and numerous municipalities throughout the United States. The CDC estimates that only 10 percent of the outbreaks of food-borne disease that occur each year are reported. If that assumption is true, then over two million individuals each year suffer from some type of food-borne disease.

The two stories above, salmonellosis from raw hamburger and the outbreak of staphylococcal food poisoning on the aircraft, are examples of two different types of food-borne disease. These are: *food-borne infection* when specific bacteria are present in the food. After you eat the food, the bacteria grow in your intestines and bring about illness. Only a few bacteria are necessary to establish the infection. The second is *food intoxication* when specific bacteria grow in the food and produce a toxin or poison. When you eat the food, this poison causes illness.

FOOD-BORNE INFECTION

Salmonellosis is a food infection. In this type of outbreak,

the food serves as a carrier of the causative bacteria, *salmonellae* species. Growth of the microorganism in the food is not necessary for the illness to occur. But growth in the food increases the likelihood of infection resulting. The organism grows in the gastrointestinal tract releasing an endotoxin, which causes the symptoms. Onset of symptoms is related to the number of bacteria ingested with the food, the greater the number of cells (millions per gram of food), the faster the onset of symptoms. Generally, occurring anywhere from 8 to 72 hours after ingestion of the contaminated food, salmonellosis is characterized by an abrupt onset of diarrhea, nausea, abdominal pain, prostration, chills, fever, and vomiting. Symptom intensity varies from slight to severe discomfort and, in extreme cases, can result in death. The mortality rate is low (less than one percent) and generally is confined to infants, older people, and those suffering from other diseases.

The microbe, which causes salmonellosis, may be any one of over 1,600 different serotypes that have been identified. Cultivation, isolation, and identification in a microbiological laboratory require several days and eventually serotyping with known antisera to identify positively the specific serotype. It is not a difficult task but requires a working knowledge of microbiological techniques and laboratory experience.

The organism is an inhabitant of the intestinal tract of warm and cold-blooded animals. It is usually associated with fecal material but can also be isolated from non-fecal material as well. Bryan, in his summary on "The Status of Food-borne Disease in the United States," suggests that current epidemiologic evidences indicates that domestic farm animals are major sources of salmonellae.³

The salmonella cycle consists of animals becoming infected from feed or from the farm environment, i.e., manure from previously infected animals. The contamination increases as the animals are transported to abattoirs, kept in pens with other animals, and eventually slaughtered. In this situation, one infected animal can contaminate many. After slaughter, the offal (gastrointestinal tract, stomach, hoofs, bones, and so on) are used as protein sources for animal feed. These waste products are frequently contaminated with

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salmonella and, subsequently, the animal feed is contaminated and the cycle continues.

In order for the outbreak of salmonellosis to occur, the food, when consumed, must be contaminated with salmonella in any of the following ways: (a) food contaminated with fecal matter during processing, (b) contaminated raw foods, such as hamburger in the above example, consumed raw or used in prepared foods that receive no further heat treatment, or are given heat treatment insufficient to destroy the salmonellae, (c) cooked, prepared foods contaminated from unclean equipment previously used to handle raw food and (d) workers, who previously handled raw food or who may be carriers, with poor personal hygiene practices.³

Once the food is contaminated, further mishandling, such as improper storage temperature, allows the salmonellae organisms to grow to numbers sufficient to cause the illness. Growth is not always necessary as small numbers of several serotypes can cause the illness. Two factors lead to outbreaks of food-borne salmonellosis—the first, contamination of the food with the microbe and second, mishandling of the food allowing growth to occur.

Obviously, the food must be ingested before the illness results. Growth of these bacteria in the food does not alter the flavor, aroma, appearance, and taste of the food in any way. The only way to ascertain the presence of salmonellae in foods is by proper microbiological analysis in a laboratory accustomed to working with food.⁴

Control of outbreaks of salmonellosis is dependent upon interrupting the salmonella cycle described previously. If this cycle of infection can be broken in several places, then a reduction in numbers of outbreaks of salmonellosis will occur. Regulatory agencies are attempting to reduce the occurrences of salmonellosis by controlling several of the possible sources in the cycle. But to achieve this control will require the cooperation of all who are interested in a safe food supply.

CLOSTRIDIUM PERFRINGENS FOOD-BORNE ILLNESS

How would you like to purchase 13,500 get-well cards? Improper handling of beef used in a school program resulted in this many cases of *Clostridium perfringens* food-borne illness.⁵ The beef had been cooked the day before serving, improperly cooled overnight, and inadequately cooked before serving—two important factors which contribute to outbreaks of this type of food-borne disease.

This illness is not as easily classified as an infection or intoxication as the two previously mentioned. Both elements of infection and intoxication are involved. Extensive growth of this microbe in the food is necessary before illness will result. Once ingested, the organism continues to grow in the intestinal tract producing spores. When the spores are formed, a toxic substance is released, which causes the symptoms.

In comparison to other forms of food-borne illness, *C. perfringens* food-borne illness is a relatively mild one. The symptoms are intestinal gas, diarrhea, cramps, occasional nausea and, rarely, fever or vomiting. How many times have you been affected with similar ones and passed them off as a virus or “something that’s going around?”

This particular food-borne illness has been tagged as a

problem of the food service industry. Reported outbreaks are generally associated with banquets, picnics, and meals that are served at large gatherings of people. It is most generally caused by food that is prepared in advanced and kept warm until served.⁵

The microorganism involved, *Clostridium perfringens*, is an anaerobic, spore-forming rod with rather fastidious nutritional requirements. It requires several preformed amino acids and vitamins for growth. Few foods, other than meat, poultry, soups and gravies made from these foods, contain these necessary growth factors. Since this microbe also forms spores, it can survive cooking.

The conditions needed for an outbreak of *C. perfringens* food-borne illness to occur are: (1) the food must contain *C. perfringens*, (2) the food must be suitable for its growth, (3) temperature of the food must be suitable for its growth, (4) there must be sufficient time for growth to occur, and (5) the contaminated food must be eaten.

Outbreaks of *C. perfringens* food-borne illness can be prevented by following the guidelines given below.

1. Preparing food several hours or a day before serving is hazardous and should be avoided.
2. Leftover, cooked meat should not be merely warmed up but heated to at least 165°F., internal temperature, to destroy vegetative cells of *C. perfringens*. Or, cut the meat into small pieces and boil it until the meat is completely heated to assure destruction of vegetative cells.
3. Once reheated, leftover foods should be eaten while hot or kept hot until consumed.
4. Food to be served hot should be kept above 140°F. until served.
5. All foods not eaten while hot or that cannot be held at 140°F. must be chilled rapidly and refrigerated at 45°F. or below.
6. Never allow hot foods to cool slowly to room temperatures before refrigerating. The slow cooling period provides an ideal growth temperature for the bacteria.
7. Room temperature should not be used to cool foods. Mechanical refrigeration, particularly large walk-in type rooms with circulating air, are more efficient for rapidly cooling food.
8. Foods should be refrigerated immediately after removal from a steam table or warming oven.
9. Food in shallow pans cools much faster than food in deep pans. Ice baths or cold running water also can be used to cool food rapidly for storage.

Observation of these precautions will not only help prevent outbreaks of *Clostridium perfringens* food-borne illness but also others such as salmonellosis and staphylococcus food poisoning. In addition, food spoilage caused by the growth of other types of bacteria will be minimized.

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DOCTORS' NOTEBOOK

Trustees' Minutes October 15, 1978

A regular meeting of the Board of Trustees was held on Sunday, October 15, 1978, at the Executive Offices, Trenton. Detailed minutes are on file with the secretary of your county medical society. A summary of significant actions follows:

Chiropractic Suit Against the AMA and Others . . . Noted that the national medical specialty societies, along with the American College of Radiology, the American College of Surgeons, the American College of Physicians, and the American College of Orthopaedic Surgeons, have petitioned the Federal District Court in eastern Pennsylvania to oppose the settlement of a suit brought by a chiropractor and his association against the AMA and seven other medical organizations. They claim, among other issues, that the AMA Board of Trustees does not have legal authority to settle the suit because the settlement contravenes the *Principles of Medical Ethics*. The AMA disagrees, asserting that the settlement does not contravene the *Principles of Medical Ethics* adopted by the House of Delegates and that the Board of Trustees has plenary authority over the affairs of the association when the House is not in session. (Board of Trustees has the power and duty to carry on whatever transaction the corporation or association itself has the power to carry on—Webster—*The Law of Associations* 2-76, 2.07 (1) (a).) An opinion on whether the AMA has the right to settle the suit is expected by the end of October.

Proposed Rule on Dispensing Amphetamines 10 NJR 446 (a) . . . Directed that a communication be directed to the State Board of Medical Examiners advising that MSNJ is of the opinion that it is the prime responsibility of the State Board of Medical Examiners to notify each licensed physician of the rule on dispensing amphetamines and sympathomimetic amines. The proposal covers

the prescribing, administering, or dispensing of these drugs.

Proposed Rule on Standards for Testing and Diagnostic Centers 10 NJR 446 (b) . . . Directed that a communication be sent to the Board of Medical Examiners reiterating the position of MSNJ on health testing and diagnostic centers that a patient must be referred for multiphasic health testing by a physician, with a report to the referring physician, and that once the report is received and opened the physician is obligated to perform professional services for that patient. The proposed rule is a mechanism to regulate the mobile van automated screening centers and would cover stationary "automated health testing centers." It appears not to have a significant adverse impact on the practice of medicine.

Marsh vs. Finley . . . Noted that the State Supreme Court has refused to grant certification in the Department of Health's suit against Dr. Marsh re exemption of physicians in private practice from the certificate-of-need law. The decision of the Appellate Division that a physician in private practice can purchase and operate a CAT scanner without a certificate of need is now standing law in New Jersey. The Radiological Society has been asked to establish a clear position on the placement of expensive modalities (despite the Marsh case) if the Society is to prevent a rash of subsequent cases and unfavorable decisions by the Department of Health concerning the designation of health care facilities.

Voluntary Cost Containment (AMA, AHA, FAH) Meeting . . . Authorized payment of expenses incurred by the representative of MSNJ who attends the Voluntary Cost Containment meeting in Chicago, November 7 and 8, in the event these expenses are not covered by the Voluntary Effort national staff.

Legislation . . . Approved the Council on Legislation's recommended position

on bills of medical import, with the exceptions noted:

S-497—Greenberg—Professional Licensing Boards

Grants the Attorney General concurrent jurisdiction with the professional boards when, after notice, a given board has failed to execute its legal responsibility. Additionally, provides for uniform enforcement powers and procedures among the various boards. This legislation would not appear to impact severely on a reasonable and active professional board. LAW c.73 ('78)

S-828—Dodd—Dental Anesthesia

Prohibits dentists from administering a local or general anesthesia unless they have passed a course in anesthesia which has been approved by the New Jersey Board of Dentistry. **DISAPPROVED**, because the rules and regulations adopted by the New Jersey [Board of Dentistry] to regulate the administration of general anesthesia would make this legislation redundant. (Words in brackets substituted by the Board of Trustees in place of "Dental Association.")

S-898—Dodd—Controlled Dangerous Substances

Decriminalizes marihuana possession in regard to the recreational use of marihuana and hashish since (according to the sponsor) scientific evidence "overwhelmingly proves that traditional beliefs of the ill effects of marihuana usage have been generally mendacious and medically erroneous." **DISAPPROVED**, in accordance with Resolution #8 adopted by MSNJ's 1978 House of Delegates. Also, because this bill would lead the public to believe that there are no ill effects from the usage of marihuana, when, in fact, there is no scientific evidence to support such a statement.

S-990—Skein—Local Health Services Act

Exempts municipalities with a population of less than 15,000 from the requirements of implementing the Local Health Services Act. **NO ACTION**

S-1038—Bedell—Dental Practice

Would amend the existing statutes and existing common law to allow persons and organizations other than licensees to provide or offer dental services as long as the professional services are actually performed by licensees. **ACTIVE OPPOSITION**, because this bill would depart from existing New Jersey law and would place an added inflationary impact on the cost of health care services. It would also enable non-practicing individuals to profit from the conduct of a professional practice.

S-1042—Bedell—Nursing Services (Blue Shield Coverage)

Permits policies at the option of the subscriber to provide direct reimbursement to nurses for nursing care if the nurse is not paid a salary by any health care provider for the

duties so performed. **NO ACTION**
S-1043—Bedell—Nursing Services (Individual Health Insurance Contracts)

Same as **S-1042** except it applies to individual commercial insurance contract benefits. **NO ACTION**

S-1044—Bedell—Nursing Services (Group Health Insurance)

Same as **S-1042** except it is applicable to group health insurance contracts. **NO ACTION**

S-1053—Maressa—Local Government Employee Coverage for Health Services

Allows local government entities to make direct payments to health and welfare plans rather than through insurance carriers. **CONDITIONAL APPROVAL**, pending an amendment to the bill that would allow the free choice of physicians, dentists, providers of services and health care facilities to employ beneficiaries.

S-1077—Weiss—Products Liability of Pharmaceutical Products

Requires all drug manufacturers in New Jersey to carry:

(a) product liability insurance according to minimum standards of the Insurance Commissioner

(b) provide product liability indemnity protection to each pharmacist retailing their products

CONDITIONAL APPROVAL, provided the following amendment is added to the bill: "(c) provide products liability indemnity protection to each physician prescribing or dispensing their products."

S-1110—Maressa, et al—Abortions

This bill attempts to regulate abortions in some instances and to prohibit them in others. It provides:

(a) 1st Trimester—may be done electively by physicians after written consent of the patient. The informed consent involves:

(1) The diversity of dangers inherent in the abortion procedure, including but not limited to the possibility of immediate and long-term physical dangers, psychological trauma, sterility, increases in the incidence of premature births, tubal pregnancies and still births in subsequent pregnancies.

(2) The particular complications of the procedure to be used.

(3) Physical competency of the unborn child at the time the abortion is to be performed, and the specific biological facts concerning the development of the unborn child.

(4) Positive alternatives to abortion including childbirth and adoption.

There shall be an interval of not less than 48 hours between the time a woman signs the consent form and the abortion procedure is performed.

(b) After the 1st trimester abortions can be performed only after securing the informed consent detailed above and:

(1) Must be performed in a hospital.

(2) A determination must be made whether or not the fetus is viable.

(3) If the fetus is viable, the procedure must be necessary to preserve the health or life of the mother and two other physicians must support that conclusion in consultation.

(4) All efforts must be used to preserve the life of a viable fetus and a second physician must be in attendance to assist the aborted fetus.

ACTIVE OPPOSITION, pending the removal of Section (9) parental notification and Section (10) saline amniocentesis from the

bill. (Council's recommendation of "conditional approval" was changed as indicated as the Board felt this legislation is an intrusion on the private practice of medicine.)

S-1192—Perski—Physicians' Assistants

Permits the use of physicians' assistants when the P.A. has a valid registration with the State Board of Medical Examiners, a protocol and job description filed with the State Board and supervision by a licensed physician. No physician may supervise more than one P.A. **CONDITIONAL APPROVAL** requiring modifications to preserve quality care and reduced costs. (Council's recommendation of **active opposition**, because the need for this type of legislation has not been clearly established, plus the lack of evidence that physicians' assistants would produce a lower cost to health care services, was defeated—see "Physicians' Assistants," page 942 this issue.)

S-1199—Dumont—Protection of the Elderly

Makes it a crime to abandon, neglect, or abuse the elderly. Physicians and other practitioners (some licensed, some not licensed, and some no longer existing) who have reasonable cause to suspect that an elderly person (anyone over 60) has been abused, neglected, exploited, or abandoned or is in need of protective services shall report the same in any reasonable fashion to the Office of the Ombudsman for the Institutionalized Elderly within 5 calendar days. Failure to report carries a fine of \$500.

Persons reporting under the Act are immune from civil or criminal liability unless they acted in bad faith, or with malice, or have committed perjury. **ACTIVE OPPOSITION** (Council's recommendation of **approval** was changed as indicated, not that the Board is against reporting situations detrimental to the elderly but disapproved the mandatory aspect of the bill.)

S-1223—Dorsey—Tort Immunity

Extends governmental immunities to private physicians performing services for public entities whether as volunteers or independent contractors. **APPROVED**

S-1234—Weiss—Consent to Elective Surgery

Requires physicians to secure specific written consent to elective surgical procedures which shall indicate the operating surgeon and identify any other participating physicians. The primary surgeon must be in continuous attendance unless an emergency occurs, in which event his absence shall be noted in the operative record. The operative record which must be kept shall indicate the name, position, and duties of each person in attendance at such operation. This record must be available for at least one year at both the hospital and the physician's office and available for the patient's inspection and reproduction. **ACTION DEFERRED**, pending further action from the Ad Hoc Committee consisting of Doctors Rush, Todd, Krueger, Parsonnet, and O'Regan.

S-1248—Orechio—Electrologist Licensing Act

Provides for the registration and licensing of electrologists under the rule and regulation of the State Board of Medical Examiners. Electrology is defined as the art which effects the permanent removal of superfluous hair from apparently normal skin of the human body by electrical, electronic, or other technical scientific methods approved by the Board. **NO ACTION**

A-3—Burstein—Wrongful Death Damages Related to Minors

Would expand existing laws on the measurement of damages in wrongful death actions of minors. It would permit compensation for the loss of the pecuniary investment of the parents including the cost of birth and rearing of the child. **NO ACTION**

A-162—Jackman—Optometry

Makes it a violation of law for an optometrist to locate a practice within geographical proximity to a retail optical outlet so as to induce patronage to himself thereby. **NO ACTION**

A-942—Burstein—Medical Malpractice Reinsurance Plan

Amends the existing reinsurance facility law to recognize traditional insurance techniques for the determination of losses for those persons insured through the State facility. Allows the facility to directly write insurance. Losses would be made up by surcharge levies made against persons holding insurance through the facility. **NO ACTION**

A-1064—Pellecchia—Ophthalmic Technicians

Repeals existing licensing laws related to ophthalmic technicians since they are mere production employees and have no real patient contacts. **NO ACTION**

A-1065—Pellecchia—Medicaid

Expands Medicaid eligibility to those persons whose income and resources place them at less than one and one-third times current eligibility ceilings. This would not produce a drastic expansion in the scope of the covered population. **APPROVED**

A-1071—Hurley—Withholding or Withdrawing of Life Sustaining Procedures in Event of Terminal Illness

Empowers adults to execute a statutory form of directive to their physicians providing for the withholding or withdrawing of life sustaining procedures during a terminal illness. The directive would be valid for five years and provides immunity for physicians and other providers complying with such a directive.

"Life sustaining" means a modality or intervention which utilizes mechanical or other artificial means to sustain, restore, or supplant a vital function which would serve only to artificially prolong the moment of death where, in the judgment of the attending physician, death is imminent whether or not such procedures are utilized. It does not include "the administration of medication or the performance of any medical procedure deemed necessary to alleviate pain." **APPROVED**

A-1095—Gormley—Tay-Sachs Screening

Allows counties to appropriate annually up to \$10,000 to support voluntary Tay-Sachs screening and counseling programs. Matching state aid is to be made available via the Department of Health. **APPROVED**

A-1105—Lesniak—Informed Consent for Elective Surgery

Requires physicians to secure specific written consent to elective surgical procedures which shall indicate the operating surgeon and identify any other participating physicians. The primary surgeon must be in continuous attendance unless an emergency occurs, in which event his absence shall be noted in the operative record. The operative record which must be kept shall indicate the name, position, and duties of each person in attendance at such operation. This record must be available for at least one year at both the hospital and the physician's office and available for the patient's inspection and repro-

duction. **ACTION DEFERRED**, pending further action from the Ad Hoc Committee consisting of Doctors Rush, Todd, Krueger, Parsonnet, and O'Regan.

A-1110—Visotcky—Second & Third Surgical Opinions

A-1111—Visotcky—Second & Third Surgical Opinions

A-1112—Visotcky—Second & Third Surgical Opinions

These bills require Blue Shield, individual health insurance contracts, and group health insurance contracts to require second opinions in all elective surgical cases as a precondition to payment.

In addition, when the first and second opinions differ the contract shall provide for a third opinion should the patient so desire one. **DISAPPROVED** The patient should be given the option of whether or not to seek a second or third opinion at the expense of the insurance carrier.

A-1116—Stewart—Joint Underwriting Associations

Grants civil immunity to the Insurance Department and insurance companies participating in the various joint underwriting associations which are or may become operative in New Jersey. **NO ACTION**

A-1119—Jackman—Chiropractic

Creates a separate chiropractic licensing board within the Division of Consumer Affairs and transfers all functions of the State Board of Medical Examiners related to the regulation of chiropractic to the newly created board.

It does not change the definition of chiropractic nor the scope of practice. **DISAPPROVED**, because this bill would be unnecessary legislation.

A-1123—Weidel—Withholding of Life Sustaining Procedures in Event of Terminal Illness

Same as A-1071 **APPROVED**

A-1132—Weidel—Blood Donations

Provides for a \$25 deduction from gross income for each pint of blood a given taxpayer donates to nonprofit blood-collecting organizations. **APPROVED**

A-1155—Deverin—Arrests of Apparently Intoxicated Persons

Requires police officers when making arrests of apparently intoxicated persons to examine those persons for the presence of medic alert bracelets or other forms of identification. **APPROVED**

A-1285—Deverin—Abortion

Attempts to regulate abortions. During the first trimester the physician must secure written consent of the patient which demonstrates that she has been advised of the inherent dangers in abortions, dangers to the unborn fetus, and alternatives to abortion. Abortions could not be performed until 48 hours after the consent was obtained.

After the first trimester the physician must advise that a live-born infant may result; that the abortion must be performed in a hospital. If the abortion is not necessary to preserve the life or health of the mother, it cannot be performed until the attending physician certifies whether or not the "unborn child" is viable with reasonable medical certainty. If the "unborn child" is viable the physician may not perform the abortion unless medically necessary to preserve the life or health of the mother and only after consultation with two unrelated physicians.

If the "unborn child" is viable a second physician must be in attendance and care

must be taken to preserve the life of the "unborn child."

No such "live-aborted" infant may be used for experimentation or research. **CONDITIONAL APPROVAL**, pending the removal of Section (9) parental notification and Section (10) saline amniocentesis from the bill.

A-1286—Stewart—Automobile No-Fault Insurance

Restructures the No-Fault Law to create the hopeful expectation of a viable and flexible commercial market. The section of this bill of interest to the medical profession is that which would empower the Insurance Commissioner to create regional review boards to promulgate schedules of reasonable fees for medical services for the most common forms of injuries. These schedules shall constitute maximum payment schedules for insurers. The boards may waive the scheduled fees when special circumstances require departure from such schedules. Claims presenting a question of fraud are to be referred to the Attorney General.

The review boards shall consist of two physicians, two attorneys, two insurance executives, and one public member. **APPROVED**

A-11294—Bornheimer—Insurance Payments for Dental Services

A-1295—Bornheimer—Insurance Payments for Dental Services

A-1296—Bornheimer—Insurance Payments for Dental Services

This three-bill package requires insurers to reimburse patients for services performed by dentists, if such services are covered when provided by physicians. (Blue Shield-Group Contracts-Individual Contracts) **APPROVED**

A-1314—Hurley—Physicians' Assistants

Provides for legal recognition of a physician's assistant who is duly registered with the State Board of Medical Examiners and provides certain services under the supervision of the employing physician. (Supervision means specific direction, but does not require the physician to be on the premises at all times.)

CONDITIONAL APPROVAL* requiring modifications to preserve quality care and reduced costs. (Council's recommendation of **active opposition**, because the need for this type of legislation has not been clearly established, plus the role and function of physicians' assistants is not definitively described in that direct personal supervision is not required by this proposal, was defeated—see "Physicians' Assistants," page 942, this issue.) (*MSNJ continues to oppose this bill.)

A-1321—Orechio—Cardiopulmonary Resuscitation

Requires school boards to offer CPR as a mandatory course for all high school students. **ACTION DEFERRED**, pending further information from the Committee on Emergency Medical Services.

A-1351—Bassano—Advertising by Professionals

Deletes any jurisdiction over licensee advertising by the State Board of Medical Examiners or the Board of Psychological Examiners. **ACTIVE OPPOSITION**, because this bill takes away all restrictions and regulations with regard to advertising and precludes reasonable restraints which would be necessary to safeguard the public.

A-1387—Otlowski—Physicians' Assistants (Same as S-1192)

CONDITIONAL APPROVAL requiring

modifications to preserve quality care and reduced costs. (Council's recommendation of **active opposition**, because the need for this type of legislation has not been clearly established, plus the lack of evidence that physicians' assistants would produce a lower cost to the health care services, was defeated—see "Physicians' Assistants," page 942, this issue.)

A-1426—Lesniak—Commitment of Criminally Insane

Provides that the determination of the sanity of any confined person is an issue for the Court and not a jury.

If the issue of insanity is raised at trial as a defense and the jury acquits a post trial hearing, the judge shall determine whether institutionalization or lesser restraints are indicated.

Testimony of psychiatrists will be the controlling issue. **ACTION DEFERRED**, pending further information from the Council on Mental Health.

A-1441—Karcher—Peer Review Immunity

Grants civil immunity for peer review activities including those of professional societies. (Same as S-777) **ACTIVE SUPPORT**

... Approved the recommendation from the Council on Legislation that the following bills be noted and filed as not being of intimate concern at this time:

S-560—Musto—Health Statistics

Deletes the listing of color from reports on cases of venereal disease, T.B., dog bite, and marriage licenses. Further, applicants for the barber's examination shall not be required to submit two signed photographs with their applications.

A-1340—Orechio—Sex Education

Mandates Boards of Education to provide sex education for all pupils K-12. Pupils may be excused upon the written request of their parents.

ACR-114—Orechio—Commission to Consider Retesting of Health Professionals

Creates a legislative commission to study health professional licensing laws; to assess whether or not there are indeed manpower shortages, and to consider the concept of periodic retesting of licensees to determine clinical ability and currency via new techniques and methodologies.

ACR-131—Girgenti—Commission to Study Cost of Health Care for the Institutionalized Elderly

Creates a legislative commission which is to study the cost of institutionalized care for the elderly and consider the option of a comprehensive system of home health care as an alternative.

AR-41—Orechio—Generic Drug Substitution Law

Calls for an evaluation of the generic substitution law by December 1, 1978, to determine whether or not an actual savings to the consumer has been forthcoming. (Note: The therapeutic equivalency list required under the act has not been finally adopted at this date. August 23, 1978)

Equal Compensation for Physicians' Services in Office or Hospital ... Noted that the Public Advocate believes it in the public interest to mandate uniform third party reimbursement for physicians' services whether provided in a hospital or

as out-patient care and requested MSNJ assistance in developing legislation to effect this policy. MSNJ had suggested a reduction in cost might be possible if services now performed in hospitals (which could be performed safely in a physician's office) were carried out in the physician's office. Mr. Steven Blader, Assistant Deputy Public Advocate, has been invited to attend the next meeting of the Council on Medical Services.

Medicaid Reimbursement . . . Noted that a recommendation from the Executive Committee that State funds be re-allocated to increase Medicaid reimbursement rates was being considered by the appropriate State agencies, and that the State has expressed its willingness to cooperate in an effort to establish a more efficient and economical health care system.

Annual Meeting . . . Noted the following concerning plans for the 1979 annual meeting:

(1) Ralph J. Fioretti, M.D., has accepted appointment as Chairman of the Annual Meeting Committee;

(2) A \$200 honorarium and expenses will be paid to out-of-state speakers only;

(3) General topic for the 5th Annual Governor's Conference will be "Medicine and Federal Regulations";

(4) The House of Delegates' sessions will be held in the grand ballroom at the Convention Hall;

(5) Space will be available for information and scientific exhibits in the Boardwalk Regency (formerly Howard Johnson Regency);

(6) The inaugural reception and dinner dance honoring the President-Elect will be under the direction of the county of the President-Elect; the expense of the dinner-dance will be made up by sale of tickets and contribution from the sponsoring county society. The cost of the reception will be the responsibility of MSNJ and the Board authorized a charge of \$5 per person. (There will be a combined price for those attending the reception and dinner.)

Health Care Administration Board . . . Received a written report from Anthony P. DeSpirito, M.D., on his attendance at the October 5th meeting of the Health Care Administration Board and took the following actions thereon:

(1) When published, the Proposed Manual of Standards for Hospital Facilities: Section One—Cardiac Diagnostic

Facilities and Cardiac Surgical Centers will be referred to the appropriate specialty societies;

(2) The matter of Computerized Axial Tomography Services—Free Standing Ambulatory Care Facilities was referred to the Radiological Society of New Jersey;

(3) Amendments to HMO certificate-of-need regulations were referred to NJFHCE with the request that the Foundation study and consider the feasibility of a statewide IPA/HMO.

. . . Noted that Daniel J. O'Regan, M.D., has agreed to accept appointment as MSNJ's representative to the monthly meetings of the Health Care Administration Board.

Audit Review . . . Approved the following report and took the indicated actions on the recommendations from the Special Committee on Audit Review (fiscal year 1977-1978):

1. *General Fund* balance unappropriated was down to \$101,296 as of May 31, 1978 as a result of the down payment on MSNJ's new headquarters (\$222,742), transfer of *The Journal* deficit (\$24,709), Annual Meeting deficit (\$25,068), prior year fiscal expenditures (\$6,031), and an excess of 1977 expenses over revenue (\$65,548). However, closing on sale of MSNJ present headquarters (9/29/78) would result in an approximate balance of \$253,000. This is in keeping with the policy (adopted 10/20/74) that MSNJ maintain a four to six-months' operating reserve, currently estimated at \$65,000 a month.

2. *Assessments Earned* as of May 31, 1978, compared to May 31, 1977, were lower—7,450 and 7,451 dues-paying members—as of September 30, 1978 the count was 7,919 and on the same date in 1977 it was 7,886. The Audit Committee feels more should be done through the Board of Trustees to give positive direction to the county societies in recruiting membership.

3. The Audit Committee believes *The Journal* account is being monitored satisfactorily and that there are signs that the deficit has peaked and is leveling off. The effect of recent changes in *Journal* graphics to increase usable page space and a 10 to 16.6 percent advertising rate increase (1/1/79) should help further in holding down the deficit.

4. The Committee noted that MSNJ expended in excess of \$72,000 for an *annual meeting* which less than ten percent of the membership attended, and suggested consideration be given to changing the site to the new head-

quarters after modifying the format of the annual meeting.

Recommendation—That the Board of Trustees refer the matter of streamlining the format of the annual meeting to the Committee on Annual Meeting for study and report. **Approved**

5. The Audit Committee discussed the hard-to-measure benefits of the \$117,812 expenditure on *public relations*. **Recommendation**—That a survey group be contacted as to the cost to conduct a public relations survey that would give some measured results. **Referred to the Council on Public Relations.**

(6) It was noted that interest yield on the *General Fund* was \$40,809 compared to \$37,722 on May 31, 1977.

(7) The *Medical Student Loan Fund* investment income was \$798 higher than that of the previous year. Donations have dropped considerably and the Committee urges the Board of Trustees to remind the component societies that the Fund needs contributions so as to grant as many loans as possible—the demand well exceeds the available monies.

(8) The total interest earned on the *Professional Liability Account* was \$49,090 and the fund balance is approximately \$1,068,000, of which \$900,000 is invested at an average rate of 7.5 percent. Billing for mandatory assessments has yielded an additional \$98,990.

(9) The *format of the Audit Report* was felt to be too repetitive and the Executive Officer recommended that in the future there be included only the comparative balance sheet, the comparative statement of revenues and expenses, and the comparative statement of the general fund balance unappropriated, along with comments and recommendations of the external auditors.

Recommendation—That the Audit Report as a whole be approved with commendation to the Treasurer and the Director of Finance and Administrative Services. **Adopted.**

Physicians' Assistants . . . Took the following actions on MSNJ's position on Senate Bill 1192 and Assembly Bill 1314* and 1387:

(1) Voted to defeat (8 to 9) the recommendation of the Council on Legislation that MSNJ's position on S-1192, A-1314* and A-1387 be active opposition.

(2) Voted to adopt (12 to 5) the posi-

(*MSNJ continues to oppose this bill.)

tion on S-1192 A-1314* and A-1387 of *condition approval* requiring modifications to preserve quality care and reduced costs.

(3) Voted to defeat (7 to 10) a motion calling for a special session of the House of Delegates to discuss current legislation on physicians' assistants.

(4) Voted to defeat (7 to 8) a motion to poll the membership by mail to determine whether they favored physicians' assistants and whether they would employ same.

The majority and minority reports of the Ad Hoc Committee on Physicians' Assistants and discussion preceding the above-listed actions revealed that since 1971 the AMA has gone on record as recommending the use of physicians' assistants, and, in collaboration with the AAFP, the AAP, the AAPA, the ACP and the ASIM, has established a joint review committee for physicians' assistants' training programs. Forty-four states have enabling legislation to permit use of physicians' assistants; five states passively allow physicians to use them in their private practice. At least three states are having second thoughts on the matter and some others are in the process of tightening regulations for physicians' assistants. In 1971 MSNJ's House of Delegates, on recommendation of the Council on Medical Services, approved the concept of physicians' assistants. Recent years revealed a change in attitude and the 1978 House of Delegates voted overwhelmingly against the concept. CMDNJ has a training program for physicians' assistants which leads to a BA degree and the school is concerned that these graduates cannot practice in New Jersey except in VA hospitals. If the bills become law physicians' assistants would be limited to one per employing physician or one per 50 hospital beds under the direction of a physician; there would be initial registration, certifying examinations and continuing medical education requirements—the responsibility of the State Board of Medical Examiners. An independent telephone poll of one percent of the membership showed that the concept was favored. The Ad Hoc Committee voted three to two to oppose the premise of physicians' assistants in view of the action of the 1978 House of Delegates and the failure of a proved need for these practitioners. It was noted that the legislation under consideration does not *mandate* use of physicians' assistants, but *permits* their use under prescribed methods. The Board had the following options:

(1) to reaffirm the position of opposition to physicians' assistants,

(2) to approve the proposed legislation,

(3) to assume a position of not opposing physicians' assistants while defending firm convictions concerning their use which would be conveyed to the legislators.

Opposition to National Health Insurance . . . Deferred, until after the AMA interim meeting in December, action on Resolution #10 (1987 House of Delegates)—Opposition to National Health Insurance.

AMA Delegates and Alternates . . . Appointed Henry J. Mineur, M.D., AMA Delegate to fill the vacancy created by the death of Emanuel M. Satulsky, M.D.; John S. Madara, M.D. was appointed alternate delegate to fill the vacancy created by the selection of Dr. Mineur as delegate.

Legal Drinking Age . . . Referred to the 1979 House of Delegates a resolution from the Bergen County Medical Society concerning raising the legal age of drinking in New Jersey.

Blue Shield Commercial . . . Referred to the President of Blue Shield a communication from Henry A. Katz, M.D., concerning objection to a current Blue Shield commercial, "Mark My Bill Paid in Full," which he believes implies that insurance is paying the full bill when in fact the doctor is accepting less fee for service. It was directed that a copy of the communication be sent to MSNJ's representatives on the Blue Shield Board of Trustees.

(*MSNJ continues to oppose this bill.)

CMDNJ Notes*

**Stanley S. Bergen, Jr., M.D.
President**

The College currently is enjoying a boom in enrollment in its six schools, due largely to the construction of new teaching facilities, the introduction of new educational programs, and the expansion of affiliations with hospitals throughout the state.

This year, 1,554 students are studying medicine, dentistry, the life sciences, and the allied health professions at the Col-

lege. This marks an increase of 130 over last year's record enrollment, and shows an expansion of nearly 1,000 students since 1970, when CMDNJ was created by an act of the State Legislature.

At CMDNJ-New Jersey Medical School there are 524 M.D. degree candidates in the school's four classes, an increase of 34 over last year. The new facilities enabled the school to increase the size of its entering class to 140 new students in the first-year class.

Also at the CMDNJ-New Jersey Medical School are 34 transfer students, including 28 in the third year and six in the second year. They are part of a continuing program at the College to bring home American students who have been studying medicine in foreign medical schools. Last year, 30 transfer students were enrolled.

At the CMDNJ-Graduate School of Biomedical Sciences, which also is housed in the Medical Sciences Building on the Newark campus, the enrollment is 105, compared with 98 last year. Included are 18 new Ph.D. and M.S. candidates and 29 non-degree students.

CMDNJ-Rutgers Medical School, Piscataway, now has 392 students, 34 more than last year. With 108 first-year students, the entering class size remains the same, while expansion continues in the school's third and fourth-year classes.

Lack of clinical training facilities had forced the school to limit its third and fourth-year classes to 56 students, causing nearly half of all entering students to leave the state to complete their M.D. studies at other institutions. Last year, however, added affiliations with community hospitals allowed the school to expand its third-year classes to 79; this year, there are 91 juniors.

An agreement which will make Middlesex General Hospital, New Brunswick, the medical school's core teaching facility, and the inauguration of the CMDNJ-South Jersey Medical Education Program, in which some students of CMDNJ-Rutgers Medical School will take their clinical years at Cooper Medical Center, Camden, will allow the school to bring its total enrollment up to 432, or 108 in each class, within the next few years.

At CMDNJ-New Jersey Dental School, Newark, there are 257 students in the school's three classes. Its entering class of 88 is the largest in the school's history. With the new facilities, and a return to a four-year program, the school expects to reach an enrollment of nearly 400 students eventually.

CMDNJ-New Jersey School of Osteopathic Medicine, Piscataway and Camden, enrolled its second first-year class of 28 students this year. They join the inaugural class in basic science training at the facilities of the CMDNJ-Rutgers Medical School in Piscataway. The osteopathic school plans to offer third-and fourth-year clinical training at hospitals in South Jersey, primarily at the John F. Kennedy Memorial Hospital in Stratford, which has been identified as its core teaching facility.

CMDNJ-School of Allied Health Professions in Newark has 248 students in the school's 12 educational programs conducted at the College, its affiliated hospitals, and, cooperatively, at other institutions of higher education in the state. Among its 138 entering students are 20 in the inaugural class of a physical therapy program conducted jointly with Kean College. Other current educational programs of the school include dental hygiene, begun last year with Essex County College; cytotechnology, medical technology, physicians' assisting, radiologic technology, nurse midwifery, and respiratory therapy.

Report from the Foundation

Daniel J. O'Regan, M.D.
Medical Director

Another year draws to a close. This is the fifth year-end message to appear in these pages. Once again, we wish to thank the Editors of *The Journal* for permitting The Foundation to furnish its message to the membership.

During 1979, there will be increased emphasis on the costs of medical care. The President will introduce the hospital "cap" bill again. The wage-and-price control efforts certainly will affect "health care." There will be more pressures from Congressional and HEW sources. New Jersey's Voluntary Cost Containment Committee has anticipated much of this. MSNJ and the New Jersey Hospital Association have demonstrated an unusual willingness to meet the challenge of Representative Rostenkowski and his colleagues. The Committee's report states that: "These recommendations clearly indicate the industry's willingness to deal with cost containment and its insistence that the *quality* of health care provided in New

Jersey *must not be jeopardized.*" (emphasis added) Quality assurance aspects of all efforts to improve efficiency remain the primary concern of your Foundation. Peer review must be maintained whether the subject is utilization (PSRO), delivery systems (IPA/HMO), regionalization (HSA), or prospective rate-setting (DRG). NJFHCF will help you to meet these and other challenges in the coming year. As we wish you the very best for the Holiday Season and the New Year, a note of sadness must be recognized. This is the last of these articles to be prepared in the Carriage House at 315 West State Street. We will be moving with MSNJ to quarters which will be more spacious and efficient, but a bit of our spirit will be left along the banks of the Delaware.

Information for the Use of Human Blood and Blood Components by Physicians*

- **Red Blood Cells (Human)**
Leukocyte Poor
Frozen
Deglycerolized
- **Whole Blood (Human)**
Modified, Platelets Removed
Modified, Cryoprecipitated AIF Removed
Leukocyte Poor
- **Heparinized Whole Blood (Human)**
- **Single Donor Plasma (Human), Fresh Frozen**
- **Single Donor Plasma (Human)**
- **Cryoprecipitated Antihemophilic Factor (Human)**
- **Platelet Concentrate (Human)**
- **Leukocyte Concentrate (Human)**

This information is supplied to conform with applicable federal statutes and regulations of the U.S. Department of Health, Education, and Welfare. *Federal law prohibits dispensing the products described without a prescription.*

Blood and blood components are biological products, and in some cases living human tissue, intended for use by physicians in the care of their patients. Professional judgment based on clinical evaluation determines the selection of components, the dosage, the rate of administration, and decisions in situations not covered in this general statement. The possible presence of certain infec-

tious agents and undesirable side effects in some recipients cannot be avoided. Therefore, this information as a whole, or in any of its parts, cannot be considered, or interpreted as an express or implied warranty of the safety or fitness of the described blood or blood components when they are used for their intended purpose.

Testing of a sample of donor blood is required before units of blood or blood components are available for use. The label of the unit may indicate the test result or bear the statement "Meets FDA Requirements." Tests include blood grouping, screening for unexpected antibodies, a serologic test for syphilis, and screening for HBsAg (Hepatitis B surface antigen).

RED BLOOD CELLS (HUMAN)

Description

Red Blood Cells (Human) are the cells that remain after the plasma is separated from whole blood at any time during the dating period. The label indicates the anticoagulant used in collecting the donor blood, the storage temperature, and the expiration date, which varies with the method of preparation.

Action

Red blood cells provide a source of oxygen-carrying capacity and red cell mass for volume replacement.

Indications

Red blood cells are the component of choice for most patients with a symptomatic deficit of oxygen-carrying capacity. This component can be used to maintain blood volume and for exchange transfusion. It is superior to whole blood for patients with cardiac disease and chronic anemia and for those requiring restricted sodium or citrate intake, for example, those with liver or kidney disease. Because of the minimal amount of plasma and hence ABO alloantibodies, red blood cell units are required when compatible non-ABO identical blood is used. If oxygen-carrying capacity replacement is required in surgery, red blood cells should be considered in preference to whole blood unless massive hemorrhage is anticipated.

Contraindications

1. Do not use when anemia and/or hypoxia can be corrected with specific products, for example, iron, B₁₂, folic acid.

2. Do not use for correcting coagulation deficiencies.

*This material was prepared jointly by the American Association of Blood Banks and the American Red Cross. It has the approval of the Bureau of Biologics (FDA).

3. Do not use unless they are ABO compatible. Crossmatching is required unless the withholding of red blood cells might result in loss of life.

4. Do not use for exchange transfusion later than five days after donation unless only older product is available.

Side Effects and Hazards

These are the same as for Whole Blood (Human) except that the removal of plasma reduces the amount of metabolites and antibodies and lessens the risk of circulatory overload.

Dosage and Administration

The amount administered depends on the clinical situation in each patient. The usual unit for an adult contains 200 ml of red blood cells, with a hematocrit of 70 to 80 percent and should raise the recipient's hematocrit about three percent. For pediatric patients and in other special circumstances, smaller volume units may be available.

Red blood cells must be administered through a filter and can be warmed to a temperature not to exceed 37°C during administration if that is clinically indicated. The rate of infusion depends on the clinical status of the patient but should not exceed four hours per unit. Fifty to 100 ml of sterile isotonic sodium chloride solution, U.S.P., can be added to red blood cells immediately prior to infusion; however, no other solutions or medications should be added to the unit.

Modifications of Red Blood Cells (Human) and recommended dosages are described below.

RED BLOOD CELLS (HUMAN), LEUKOCYTE POOR

Red Blood Cells (Human) or Whole Blood (Human) may be modified by filtration, centrifugation, batch washing, the addition of sedimenting agents, or a combination of these procedures to remove leukocytes. Such blood modifications are primarily indicated for patients with febrile transfusion reactions due to antileukocyte antibodies. The washing of red blood cells also removes plasma, and units prepared by this technique may be indicated for patients with paroxysmal nocturnal hemoglobinuria (PNH), antibodies to IgA, or other conditions requiring infusion of plasma-poor red blood cells. This product may also be desirable for patients who are candidates for transplantation; however, definitive data are not yet available. Removal of leukocytes combined with radiation also may be indicated for prevention of graft versus host disease in immuno-deficient patients. The expira-

tion date on the label will vary with the method of preparation. Except for additional side effects associated with the use of sedimenting agents, this component is similar in its dosage, administration, and hazards to those outlined for Red Blood Cells (Human).

RED BLOOD CELLS (HUMAN), FROZEN, AND RED BLOOD CELLS (HUMAN), DEGLYCEROLIZED

Red blood cells can be modified by the addition of glycerol as an endocellular cryoprotective agent. Red blood cells so prepared can be frozen for storage up to three years. Both the temperature and the time of storage depend on the concentration of glycerol added prior to the freezing of the cells. When thawed and washed to remove the glycerol, red blood cells are obtained with function and survival similar to those of liquid stored cells of a comparable age (based on the number of days after collection that the unit was frozen). In the wash procedure almost all the plasma proteins, anticoagulant, platelets, and leukocytes are removed. Red blood cells prepared by freeze-thaw or wash techniques have the same indications for use as *Red Blood Cells (Human)*, *Leukocyte Poor*. The contraindications, side effects and hazards, and dosage and administration are those outlined for *Red Blood Cells (Human)*. There is the additional hazard of intravascular hemolysis if the glycerol has not been removed adequately.

WHOLE BLOOD (HUMAN)

Description

Whole Blood (Human) is blood collected from selected human donors for transfusion. The label indicates the anticoagulant solution used, the storage temperature, and the expiration date, which varies with the method of collection.

Action

Whole blood provides a source of oxygen-carrying capacity (red cell mass), volume expansion, and proteins with oncotic and coagulation properties.

Indications

Whole blood is indicated only for those patients who have a symptomatic deficit in oxygen-carrying capacity combined with hypovolemia of sufficient degree to be associated with shock. If only the former is present, Red Blood Cells (Human) is the component of choice. Whole blood can be used for exchange transfusion and replacement of coagulation factors; however, in the absence of volume loss, coagulation pro-

teins should be replaced by specific components or concentrates. Whole blood intended to replace labile coagulation factors (V, VII, platelets) should be less than 24 hours old. Limiting the use of whole blood to these specific indications, for example, massive or exchange transfusion, makes it possible to prepare several components from most donor units and thus to maximize the use of the blood resource.

Contraindications

1. Do not use when anemia can be treated with specific products.

2. Do not use when volume can be safely and adequately replaced with other volume expanders, for example, saline, Ringer's lactate, albumin, plasma protein fraction.

3. Do not use unless donor and recipient are ABO identical. Crossmatching is required unless the withholding of blood might result in loss of life.

4. Do not use for exchange transfusion if whole blood is more than five days old, unless only older product is available.

Side Effects and Hazards

Transfusion therapy requires the judgment of a physician in the weighing of the potential benefits against the potential adverse effects. The principal hazards and side effects follow.

1. *Hemolytic transfusion reactions* occur when there is incompatibility between donor red blood cells and recipient plasma. Usually these reactions occur when clerical or other identification errors lead to an ABO mismatch. Careful protocols to assure proper identification when patient samples are drawn, during laboratory testing, and prior to the starting of a transfusion will prevent most hemolytic reactions. The more severe reactions are characterized by shock, chills, fever, dyspnea, back pain, headache, and/or abnormal bleeding. Hemoglobinemia followed by hemoglobinuria and bilirubinemia will occur. Renal shutdown may ensue. Treatment includes the stopping of the transfusion, the management of shock, and the judicious administration of fluids and diuretics.

Causes of *in vivo* hemolysis, some of which are not related to transfusions, include (a) the administration of hypotonic fluids, (b) bacterial infection of the patient or contamination of the donor blood, (c) acute hemolytic anemia from any cause, or (d) improper handling of the blood, for example, overheating, freezing.

2. *Transmission of infectious disease* may occur in spite of careful donor

selection and the testing of blood prior to infusion. Viral hepatitis may be transmitted by 0.02 percent to 2.0 percent of transfusions; the exact incidence is unknown and varies from population to population. Tests for HBsAg detect most but not all carriers of the hepatitis B virus. Much transfusion-associated hepatitis is probably due to non-A, non-B hepatitis virus(es) for which no tests exist. Cases of hepatitis vary in severity and may be fatal. Prevention of this complication is aided by the reporting of all suspected cases to the supplying blood bank, the periodic reviewing of all hepatitis cases, and the monitoring of the sources of donor blood. Malaria, syphilis in the seronegative phase, Epstein-Barr virus, cytomegalovirus, brucellosis, trypanosomiasis, Colorado tick fever, and other infections very rarely may be transmitted by blood.

3. *Immunization of the recipient* to red blood cell, white blood cell, platelet, and protein antigens may be a consequence of transfusion. This complication is not life threatening nor does it cause symptoms; however, subsequent blood or component transfusions may have to be selected to avoid serious reactions due to specific antigens to which the recipient has become sensitized. Red blood cell antibodies, which may have been stimulated by a prior pregnancy, usually will be detected in an antibody screening test and/or a compatibility test prior to transfusion. New blood samples for antibody screening and/or compatibility testing must be obtained at least every 48 hours when a patient has been transfused recently or is pregnant. In occasional patients with serologically undetected antibodies, *delayed hemolytic reactions* can develop. This type of reaction may mimic autoimmune hemolytic anemia with a positive, direct antiglobulin test.

4. *Febrile reactions* with or without chills that occur after 0.5 percent to 1.0 percent of transfusions frequently are related to prior sensitization to HLA or other antigens on leukocytes and platelets. Tests for these antibodies may be useful in deciding which patients will benefit from use of leukocyte-poor or frozen-deglycerolized red blood cells.

5. *Allergic reactions* manifested by urticaria may occur in up to three percent of recipients. Occasionally chills and fever also are observed. The exact cause of these reactions is unknown; however, they are less frequent when red blood cells are used and may be prevented in patients with a prior history of such reactions by *premedication of the*

patient with an antihistamine. In the rare individuals lacking IgA (about 1 in 500) who develop anti-IgA antibodies, anaphylactoid reactions manifested by bronchospasm, air hunger, and a sense of impending doom may occur. Immediate treatment with adrenalin and corticosteroids is indicated. IgA-deficient blood or well-washed red blood cells are required for further transfusions.

6. *Circulatory overload reactions* manifested by pulmonary edema occur when excessive volume is administered. This is a particular risk in chronic severe anemia where there is decreased red blood cell mass and increased plasma volume. The use of red blood cells and proper spacing of transfusions will minimize the occurrence of this complication.

7. *Bacterial contamination* of the donor blood is extremely rare. The presence of gram-negative bacilli may cause severe endotoxin shock, frequently associated with redness of the skin (red shock). This reaction is prevented by proper storage and handling of the blood and by the use of sterile equipment and techniques. Management must be immediate and aggressive to be life-saving.

8. *Air embolism* may complicate a transfusion if infusion under pressure is used with an open system or if air enters the system during the changing of bags and sets.

9. *Iron overload* with resultant hemosiderosis may occur in patients given repeated transfusions over long periods of time.

10. *Metabolic complications* of transfusion usually occur when massive amounts of blood are rapidly infused (amounts equal to or greater than the patient's blood volume in a few hours) or when the patient has severe liver or kidney disease. For example:

a. *Citrate toxicity* is rare but may occur if there is severe liver disease. Intravenous calcium gluconate (0.5-1 ml of 10 percent solution/100 ml of transfused blood) has been recommended to prevent this reaction. It must not be added directly to the blood pack. EKG monitoring may be helpful in detecting effects of hypocalcemia.

b. *Acidosis*, which may occur initially during massive transfusion, is usually followed by a metabolic alkalosis and almost never requires treatment. In rare cases buffers such as THAM or bicarbonate have been used successfully.

c. *Hypothermia*, with the risk of cardiac arrhythmia, may occur in

massive transfusion. Hypothermia also complicates other metabolic changes and affects oxygen release from hemoglobin. This complication is prevented by the use of a controlled warming device in line with the infusion set.

d. *Hypokalemia* may be observed in massive transfusion, and may be treated by the use of IV solutions of potassium.

e. *Depletion of coagulation proteins and platelets* is a rare complication of massive transfusion. If excessive bleeding occurs, the possibility of a hemolytic reaction complicated by DIC should be considered. Treatment with platelet concentrates and specific components with coagulation factors, for example, fresh-frozen plasma, may be useful.

f. *Microaggregates*, consisting of fibrin, white cells, and platelets, may develop during the storage of blood. The smallest of these particles may not be retained in an ordinary blood filter. The use of filters designed to remove these particles is recommended in cardiopulmonary bypass procedures. The usefulness of special filters in massive transfusion has not been established. Most of these metabolic complications are avoided if circulatory efficiency and good resuscitation are maintained.

Dosage and Administration

The amount administered depends on the clinical situation in each patient, including the rate and volume of blood loss. The usual unit for an adult contains 520±45 ml of anticoagulated blood, with a hematocrit of about 40 percent. Smaller-volume containers are available for pediatric patients and for other special uses. Whole Blood (Human) must be administered through a filter and can be warmed not to exceed 37°C during infusion if that is clinically indicated. The rate of infusion depends on the clinical status of the patient but should not be slower than four hours per unit. If the volume status of the patient requires slow infusion rates, then Red Blood Cells (Human) rather than Whole Blood (Human) should be used. *No medications or solutions should be added to Whole Blood (Human).*

Modifications of Whole Blood (Human) and recommended dosages are described later.

WHOLE BLOOD (HUMAN), MODIFIED, PLATELETS REMOVED; AND WHOLE BLOOD (HUMAN), MODIFIED, CRYOPRECIPITATED AHF REMOVED

Whole Blood (Human), Modified, has had certain labile components (see label) removed shortly after collection from

the donor. Such units are prepared in a closed system to maintain sterility. After removal of the labile component, the remaining plasma is used to resuspend the red blood cells in the original container. Except for the infrequent case needing platelets or Factor VIII replacement in addition to volume and oxygen-carrying capacity, Whole Blood (Human), Modified, has the same indications, side effects, dosage, as does Whole Blood (Human).

WHOLE BLOOD (HUMAN), LEUKOCYTE POOR

See Red Blood Cells (Human), Leukocyte Poor.

HEPARINIZED WHOLE BLOOD (HUMAN)

Heparinized whole blood is occasionally used in special circumstances, for example, when an exchange transfusion in the *adult* is indicated or when a pump-oxygenator is required. This component can be obtained by the use of heparin in the primary collection or by the conversion of a unit collected in a citrate anticoagulant. This latter approach, which is preferred because of the limited dating period of blood collected in heparin, requires the addition of recommended quantities of heparin and calcium chloride immediately prior to use.

Contraindications

1. Do not use for routine transfusion.
2. Same contraindications as for Whole Blood (Human).

Special Precautions

Heparin effect in the patient may be counteracted by the appropriate dosage of protamine sulfate.

Side Effects and Hazards, Dosage and Administration

These are essentially the same as for Whole Blood (Human).

PLASMA

SINGLE DONOR PLASMA (HUMAN), FRESH FROZEN

Description

Single Donor Plasma (Human), Fresh Frozen, is the anticoagulated plasma separated from an individual donor's blood and frozen within six hours of collection. The type of anticoagulant, expiration date, and storage temperature are indicated on the label.

Action

Plasma frozen freshly after collection and maintained as indicated on the label until just before use is a source of clotting factors, including labile Factors V

and VIII, and fibrinogen. It also can provide plasma proteins for volume expansion.

Indications

Single Donor Plasma (Human), Fresh Frozen, is indicated for use in control of bleeding in patients with clinical situations requiring replacement of labile plasma coagulation factors for which concentrates are not available. This component may be a useful adjunct in massive transfusion to prevent dilutional hypocoagulability and in patients with severe liver disease who have limited synthesis of plasma coagulation factors.

Contraindications

Do not use when coagulopathy can be corrected with specific therapy, for example, vitamin K, cryoprecipitate, or antihemophilic (Factor VIII) concentrates.

Side Effects and Hazards

Side effects and hazards include chills and fever, allergic reactions, and circulatory overload. This latter complication can be avoided by the use of specific coagulation concentrates when high levels of factors are required. The risk of transmitting viral hepatitis and other diseases is present. If large volumes are used, citrate toxicity and hypothermia may occur. Compatibility testing prior to use is not necessary; rarely, however, antibodies in the plasma can react with the recipient's red cells, causing a positive direct antiglobulin test and possibly hemolysis.

Dosage and Administration

The amount administered depends on the clinical situation and may be determined by serial laboratory assays of coagulation. The usual unit for an adult contains approximately 225 to 275 ml of anticoagulated plasma with about 400 mg of fibrinogen, 200 units of Factor VIII, and 200 units of Factor IX, as well as the other stable and labile coagulation factors. For pediatric patients and in other special circumstances, smaller volume units with proportionally less coagulation factors may be available. Immediately prior to administration, the frozen plasma should be thawed but not warmed in a 37°C water bath with gentle agitation. This component should be ABO compatible (Rh need not be considered) and administered through a filter, and no medications or solutions should be added.

SINGLE DONOR PLASMA (HUMAN)

Description

Single Donor Plasma (Human) is the anticoagulated plasma separated from

an individual donor's blood within 26 days of collection. This material is stored frozen. The anticoagulant, storage temperature, and expiration date are indicated on the label.

Action

This material is a source of fluid that contains protein.

Indications

Single Donor Plasma (Human) is indicated for volume replacement in hypovolemia and as a protein-containing fluid in selected patients with severe hypoproteinemia. This component can be used as a source of fibrinogen or Factor IX.

Contraindications

Do not use for replacement of labile coagulation factors.

Side Effects and Hazards, Dosage and Administration

These are similar as those for Single Donor Plasma (Human), Fresh Frozen.

Modifications of Single Donor Plasma (Human) and recommended dosages are described below.

SINGLE DONOR PLASMA (HUMAN), LIQUID

Single Donor Plasma (Human), Liquid, is the anticoagulated plasma collected from an individual blood donor. It differs from Single Donor Plasma (Human) in its storage and dating period (see label). This component is similar in its actions, uses, and side effects to Single Donor Plasma (Human).

CRYOPRECIPITATED ANTHEMOPHILIC FACTOR (HUMAN)

Description

Cryoprecipitated AHF is a preparation containing the antihemophilic factor (Factor VIII) obtained from a single unit of human blood. It is prepared by slowly thawing at 4°C, rapidly frozen, fresh anticoagulated plasma. The anticoagulant, storage temperature, and dating period are indicated on the label.

Action

Cryoprecipitated AHF provides a source of Factors VIII and XIII and fibrinogen.

Indications

This component is indicated for treatment of hemophilia A. It can be used in the control of bleeding associated with Factor VIII deficiency. It is also indicated in von Willebrand's disease and for replacement of fibrinogen or Factor XIII.

Contraindications

Do not use unless laboratory studies indicate the specific coagulation defect.

Side Effects and Hazards

This product may transmit viral hepatitis and other diseases. Side effects may include febrile and allergic reactions. Compatibility testing is unnecessary. ABO group—compatible material is preferred but not essential. Rh need not be considered when this component is used. In rare cases, if a large volume of ABO-incompatible material is used, the recipient may develop a positive direct antiglobulin test and hemolysis.

Dosage and Administration

The level of Factor VIII needed for therapy or prophylaxis is not precisely predictable and varies with each patient and clinical situation. The usual unit contains an average of 80 units of Factor VIII and 200 mgs of fibrinogen in about 15 ml of plasma. The material that is stored as indicated on the label should be thawed but not warmed in a warm bath at 37°C. Do not refrigerate after thawing. Thawed cryoprecipitate can be kept at room temperature for up to six hours prior to use if the container has not been entered. If the container is entered for pooling or other reasons, cryoprecipitate must be used within two hours. Cryoprecipitate must be given intravenously through an appropriate filter.

For treatment of hemophilia, rapid infusion of a loading dose expected to produce the desired level of Factor VIII is usually followed by a smaller maintenance dose every 12 hours. To maintain hemostasis after surgery, a regimen of therapy for ten days or longer may be required. If circulating anticoagulants are present, larger doses, higher activity concentrates, or other special measures may be indicated. To calculate dosage the following formula is helpful:

$$\frac{\text{Desired Factor VIII level in \%} \times \text{patient's plasma volume in ml}}{100 \times \text{Average units Factor VIII per cryo (80)}} = \text{number of cryoprecipitate bags required.}$$

For treatment of von Willebrand's disease, smaller amounts given less frequently usually correct the deficit. These patients should be monitored by appropriate laboratory studies.

PLATELETS

PLATELET CONCENTRATE (HUMAN)

Description

Platelet Concentrate (Human) is the platelets separated from whole blood collected from a single donor and suspended in a specified volume of the original plasma. The label indicates the type of anticoagulant used in collecting the donor blood, the volume, the storage

temperature, and the expiration time and date.

Action

This component corrects hemostatic deficit in thrombocytopenic patients or individuals with functionally abnormal platelets.

Indications

Platelet Concentrate (Human) is indicated for treatment of bleeding due to thrombocytopenia or functionally abnormal platelets. Platelet transfusions are not usually effective or indicated in patients with rapid platelet destruction associated with idiopathic or immune thrombocytopenic purpura (ITP) or disseminated intravascular coagulation (DIC). Platelets may be useful in patients with rapidly falling levels secondary to chemotherapy and in selected cases of postoperative bleeding.

Contraindications

Do not use if bleeding is unrelated to decreased number of, or abnormally functioning, platelets.

Side Effects and Hazards

Chills, fever, and allergic reactions may occur. The risk of disease transmission, especially viral hepatitis, is present. Repeated transfusions can lead to immunization to HLA antigens and a refractory state in the patient that may then respond only to HLA-matched platelet concentrates. Immunization to red blood cell antigens may occur because of the presence of red blood cells. When platelet concentrates from Rh positive donors are used in a young Rh negative female recipient, prevention of Rh(D) sensitization by use of anti-Rh immune globulin should be considered. Compatibility testing prior to use is not necessary. ABO-incompatible platelets can be used if they are not grossly contaminated with red blood cells. In some patients this may lead to a positive direct antiglobulin test and hemolysis. Large numbers of platelet concentrates can cause circulatory overload, citrate toxicity, and other complications related to increased volume.

Dosage and Administration

The number of platelet concentrates to be administered depends on the clinical situation in each patient. The usual unit of platelet concentrate contains not less than 5.5×10^{10} platelets suspended in 20-30 ml (if stored at 1°-6°C) or 30-50 ml (if stored at 20°-24°C) of plasma. One unit of platelet concentrate usually increases the platelet count of a 70-kg adult by 5,000/ μ l. The expected response will not occur if the patient destroys transfused platelets rapidly as in DIC, sepsis,

or when the patient is alloimmunized by previous transfusions. The usual dose in a patient with bleeding symptoms and a platelet count below 25,000/ μ l is 6 to 8 units. This dose may need to be repeated in two to four days because of the short half life of platelets (three to four days). Larger numbers of platelets from a single donor may be obtained by pheresis. This latter procedure is required when HLA-matched donors are used.

Platelet concentrates should be administered through a filter. *Certain microaggregate filters remove platelets.* Do not add medications. The container and filter may be flushed with sterile isotonic saline to maximize the number of platelets administered.

LEUKOCYTES

LEUKOCYTE CONCENTRATE (HUMAN)

Description

Leukocyte Concentrate (Human) is the buffy coat obtained by pheresis from a single donor. Usual methods of preparation include continuous or discontinuous centrifugation or filtration leukapheresis. The final product consists of leukocytes, platelets, and erythrocytes in varying amounts suspended in 200 to 500 ml of anticoagulated plasma, as indicated on the label. Agents used to increase granulocyte yields, such as hydroxyethyl starch, may be present.

Action

Leukocyte Concentrate (Human) provides a source of granulocytes.

Indications

The primary indication for Leukocyte Concentrate (Human) is as supportive therapy for patients with neutropenia who have infections not responsive to antibiotic or other modalities of therapy. The effectiveness of leukocyte concentrate in various clinical conditions is still under investigation.

Contraindications

1. If recovery of bone marrow function is precluded, granulocyte transfusion is unlikely to alter the clinical course of a neutropenic patient.
2. Must be ABO compatible.

Side Effects and Hazards

Chills, fever, and allergic reactions may occur. The risk of disease transmission, especially viral hepatitis and CMV, is present. Sensitization to HLA and red cell antigens may occur. In immunodeficient or immunosuppressed patients, graft versus host reaction can be initiated. The presence of red cells in this component can result in hemolytic reactions and other side effects as-

sociated with red blood cell transfusions. Severe reactions with fever and rigor and/or pulmonary insufficiency have been reported.

Dosage and Administration

Leukocyte concentrates obtained by centrifugation contain about 0.5-2.0 x 10¹⁰ granulocytes, 4.0-7.0 x 10¹¹ platelets, and 25-50 ml of red cells. Those prepared by filtration contain about 2.0-3.0 x 10¹⁰ granulocytes, 4.0 x 10¹⁰ platelets, and 5-30 ml of red cells. The currently recommended course of therapy is one unit of leukocyte concentrate daily until there is an apparent cure of infection—as indicated by sustained defervescence, negative blood culture, healing of an infected area—or until bone marrow recovery ensues. Thus the

number of units given will vary with each patient. Side effects can be avoided or lessened by slow administration and with the use of diphenhydramine and meperidine. The occurrence of chills, fever, or hives is an indication to slow the rate of administration but is not an indication for stopping the transfusion. Fever and chills are most frequent with the use of leukocytes prepared by filtration.

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Physicians Seeking Location in New Jersey

The following physicians have written to the Executive Office of MSNJ seeking information on possible opportunities for practice in New Jersey. The information listed below has been supplied by the physician. If you are interested in any further information concerning these physicians, we suggest you make inquiries directly to them.

ANESTHESIOLOGY—Parvin Javadi, M.D., 57 Montague Street, Apt. 9G, Brooklyn, New York 11201. Shiraz (Iran) 1964. Board eligible. Group, solo, partnership. Available.

CARDIOLOGY—Dhirendra Mohan, M.D., 757 Main Street, Apt. 30, South Portland, ME 04106. King George (India) 1967. Subspecialty, internal medicine. Board certified (IM). Group or partnership. Available July 1979.

Micha Oren, M.D., Beth Israel Hospital/Harvard Medical School, Division of Cardiology, 330 Brookline Ave., Boston, MA 02213. Tel Aviv (Israel) 1972. Subspecialty, internal medicine. Board certified (IM). Group, partnership, solo, hospital-based. Available July 1979.

Michael M. Neumann, M.D., 5415 North Sheridan Road, Chicago, IL 60640. Dusseldorf (Germany) 1971. Subspecialty, internal medicine. Board certified (IM). Group or institution. Available.

Dominick J. Passalacqua, M.D., 2392 East 5th Street, Brooklyn, New York 11223. Bologna (Italy) 1972. Cardiac laboratory for invasive and non-invasive procedures. Available January 1979.

Michael J. Zema, M.D., 23 Rosemont Avenue, Elmwood Park, New Jersey 07407. Cornell 1974. Board certified—IM. Board eligible—Cardiology. Group, partnership, solo (with or without part-time institution). Available July 1979.

DERMATOLOGY—Herbert A. Hochman, M.D., 351 East 84th Street, New York, New York 10028. Tulane 1970. Board certified. Solo, partnership, group (join or purchase). Available.

FAMILY PRACTICE—Mark H. Krotowski, M.D., 7-29 Hegeman Ave., Apt. 3H, Brooklyn, NY 11212. Tel Aviv University 1976. Board eligible. Partnership, group. Available July 1979.

Dein M. Shapiro, M.D., 3400 Eastern Boulevard, Apt. C-9, York, PA 17402. Georgetown 1976. Single or multi-specialty group. Available.

Jack A. Devor, M.D., 828 Cape View Drive, Fort Myers, Florida 33907. Hahnemann 1966. College or university health service. Available.

Elmer S. Gilo, M.D., St. Joseph Hospital, Stamford, CT 06904. University of the East (Philippines) 1973. Board eligible. Group, solo, partnership; also teaching. Available July 1979.

HEMATOLOGY—Jagmohan K. Kalra, M.D., 2 Robin Lane, Plainview, N.Y. 11803. Lady Hardinge (India) 1970. Subspecialty, oncology. Board certified (IM) (Hematology). Group, partnership, hospital. Available July 1979.

INTERNAL MEDICINE—Maung Kyaw Aung, M.D., 5324 18th Avenue, Brooklyn, New York 11204. Institute of Medicine, Burma. Subspecialty, hematology/oncology. Board certified. Group, solo, hospital-based. Available July 1979.

Jeffrey S. Garbis, M.D., 1425 John Street, Baltimore, Maryland 21217. Guadalajara. Group, partnership, specialty, multi-specialty. Available July 1979.

Harshad R. Mehta, M.D., 1007 Elkin Residence, 5501 North 11th Street, Philadelphia, PA 19141. T.N.M. College (India). Subspecialty, cardiology. Board certified. Group, partnership, solo, institutional. Available July 1979.

Jon David Green, M.D., 509 Fairview Avenue, Orange 07050 (Apt. C-1). CMDNJ 1974. Subspecialty, gastroenterology. Board certified. Solo, partnership, group. Available July 1979.

Richard M. Nisman, M.D., 550 Rossmore Road, Richmond, VA 23225. Medical College of Virginia. Subspecialty, gastroenterology. Board certified. Group, partnership, solo. Available January 1979.

Peter K. W. Chak, M.D., 200 Bethel Loop, Apt. 20D, Starrett City, Brooklyn, New York 11239. Hong Kong 1970. Board eligible. Group, partnership, associate, solo. Available June 1979.

Robert S. Goldblatt, M.D., 150 Division Street, Derby, Connecticut 06418. George Washington 1974. Subspecialty, gastroenterology. Board eligible. Group, partnership. Available July 1979.

Alan M. Nelson, M.D., 41B Monroe Street, Milford, Connecticut 06460. Georgetown 1974. Subspecialty, gastroenterology. Board certified (IM). Group, partnership. Available July 1979.

Vithal Kusuma, M.D., 1227 South Harlem, #504, Berwyn, Illinois 60402. Osmania (India) 1970. Subspecialty, gastroenterology. Board certified (IM). Hospital, group, solo. Available July 1979.

Steven Nussbaum, M.D., 891 Clopper Rd., Apt. B-1, Gaithersburg, Maryland 20760. SUNY—Downstate, 1974. Subspecialty, gastroenterology. Board certified (IM). Group, partnership. Available July 1979.

NEUROLOGY—Bharat M. Tolia, M.D., Westchester Medical Center, Valhalla, New York 10595. M.G.M. Medical College (India) 1970. Any type practice. Available July 1979.

OBSTETRICS/GYNECOLOGY—Jeffrey M. Reinkraut, M.D., 40-01 Little Neck Pkwy., Little Neck, NY 11363. Rutgers (CMDNJ) 1975. Board eligible. Group or partnership. Available July 1979.

OPHTHALMOLOGY—Pradyumna C. Butala, M.D., 2520 S. King Drive, Apt. 505, Chicago, Illinois 60616. Baroda (India) 1968. Board eligible. Partnership, associate (fulltime). Available January 1979. Zdenka F. Macek, M.D., 271 Nandina Terrace, Philadelphia 19116. Charles University (Czechoslovakia) 1966. Board eligible. Group, partnership, association, institution. Available.

ORTHOPEDICS—Michael Glen Dolin, M.D., 100 Avenue P, Brooklyn, New York 11204. NYU 1970. Board eligible. Any type practice. Available.

PATHOLOGY—Kirit V. Solanki, M.D., 3635 West College Ave., Apt. 32, Milwaukee, WI 53221. B.J. Medical College (India) 1968. Board certified. Any type practice. Available.

PEDIATRICS—Narendra V. Ambani, M.D., 1945 Corlies Avenue, Neptune 07753. Baroda (India) 1973. Board eligible. Solo, partnership, or group. Available July 1979.

R. P. Vasani, M.D., 1575 Boston Ave., #C-12, Bridgeport, Connecticut 06610. M.S. University (India) 1974. Board eligible. Group or partnership. July 1979, or sooner.

Mehboob A. Sachani, M.D., 1 Slate Creek Rd., Apt.-3, Cheektowaga, New York 14227. Seth G. S. Medical (India) 1974. Board eligible. Any type of practice. Available July 1979.

C. V. R. N. Reddy, M.D., 57 Rupert Ave.,

Staten Island, NY 10314. Kakatiya (India) 1968. Board eligible. Group, partnership, solo. Available.

PULMONARY DISEASES—Gautam Desai, M.D., 74-38 43rd Avenue, Elmhurst, NY 11373. Baroda (India) 1970. Subspecialty, internal medicine. Board certified (IM). Board eligible. Group, solo. Available.

Peter Y. Lee, M.D., 319 East 24th Street, Apt. 21D, New York 10010. NYU 1974. Board certified (IM). Board eligible (Pulmonary Diseases). Group, institution, association. Available July 1979.

SURGERY, GENERAL—Glenn Pasternack, M.D., 7660 Phoenix Drive, Apt. 1559, Houston, Texas 77030. SUNY—Downstate 1974. Subspecialty, vascular surgery. Board eligible. Group or partnership. Available July 1979.

Charles P. Clericuzio, M.D., 13030 Trail Hollow, Houston, Texas 77079. Wisconsin 1971. Subspecialty, colonoscopy. Board certified. Group, hospital-based, or academic. Available.

Hank S. Lee, M.D., Route 4, Haleyville, Alabama 35565. Catholic Medical College, 1966. Board certified. Solo or partnership. Available.

Ivan A. Shulman, M.D., 785 Burnett Avenue, Apt. 7, San Francisco, CA 94131. Pittsburgh 1972. Board eligible. Group or partnership. Available July 1979.

P. Thaker, M.D., 5 Centennial Drive, Norwood, MA 02062. Baroda (India). Board eligible. Any type practice. Available.

Michael J. Kassouf, M.D., 4 Dartmouth Ave., Apt. 3A, Bridgewater, New Jersey 08807. French Faculty (Beirut, Lebanon) 1970. Board eligible. Group, partnership, solo. Available September 1979.

SURGERY, ORTHOPEDIC—Ronald Scheinzeit, M.D., 3432 Alpine Court, Lexington, Kentucky 40502. Albany 1974. Board eligible. Group, association, partnership. Available July 1979.

SURGERY, UROLOGICAL—Stephen J. Culver, M.D., 2018 La Grange Road, Dayton, OH 45431. University of Cincinnati 1972. Board eligible. Group, partnership, solo. Available July 1979.

Steven H. Paletsky, M.D., 126 C Remington Avenue, Syracuse, NY 13210. Medical University of SC 1973. Group or partnership. Available January 1979.

John A. Fracchia, M.D., 435 East 70th Street, New York, NY 10021. CMDNJ 1973. Group, partnership, solo. Available January 1979.

UROLOGY—Hassan Ismail Alsheik, M.D., 2101 South Oak Park Avenue, Berwyn, Illinois 60402. Damascus (Syria) 1972. Group or solo. Available July 1979.

Wen-I Lin, M.D., 5917 Culzean Drive, Apt. 505, Dayton, Ohio. Kaohsiung (Taiwan) 1968. Group or partnership. Available July 1979.

Howard B. Somers, M.D., 1153 East 72nd Street, Brooklyn, New York 11234. Guadalajara 1973. Board eligible. Partnership, group, institution. Available July 1979.

213th Annual Meeting May 12-15

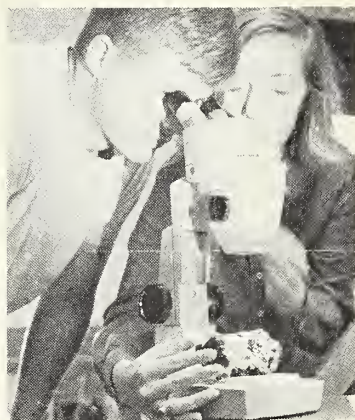
Headquarters Hotels

Holiday Inn—Boardwalk Regency

Atlantic City

(See housing application—p. 953, this issue)

The Waters of New Jersey...



of Benefit to All!

New Jersey has 1,792 miles of bountiful coastline—or 15 inches per citizen for their enjoyment and the enjoyment of visitors today and tomorrow. To insure a bright future for this important land area, the living sea and surrounding inland waters, we must recognize the need for their wise use and sensible development.

Fortunately, New Jersey is served by an organization dedicated to marine science education and research, helping New Jersey residents and industry to improve their awareness and understanding of the coastal environment and how they may best enjoy it.

The Consortium serves as a clearing house to initiate, coordinate and integrate marine science education and research in the state for both learning institutions and commerce. It has a membership of 23 colleges and universities with field offices in the Northern and Southern sections of the state and executive offices in Princeton.

The Consortium supports research and development through individuals and multi-disciplinary teams, educational programs in the classroom, in the field and on the sea.

It offers advisory services to assist individuals and organizations to obtain and exchange marine-related information at all levels.

In addition to the obvious need to conserve our shore areas for recreation, the Consortium recognizes the critical role these land areas play in our daily lives. For example, you may be surprised to learn that over 90% of all the commercial fish, shrimp, crabs, oysters, and countless other forms of marine life spend their early lives in the shelter of these wetland environments. New Jersey scientists have also found that wetlands are a natural barrier which keep underground supplies of fresh water from mixing with the undrinkable water of the



sea, thus providing thousands of New Jersey residents with pure well water. And, the state's barrier beaches and wetlands act as a natural buffer zone between the violence of the stormy ocean and the land where man lives and works.

The New Jersey Marine Science Consortium is a tax-exempt, non-profit marine education and research organization. You are invited to visit our facilities and take advantage of our many programs for students and the general public.

For more information write to:



Dr. Robert Ellis, Executive Director
New Jersey Marine Science Consortium
101 College Road East, Princeton, N.J. 08540
609-452-8465

**NEW JERSEY
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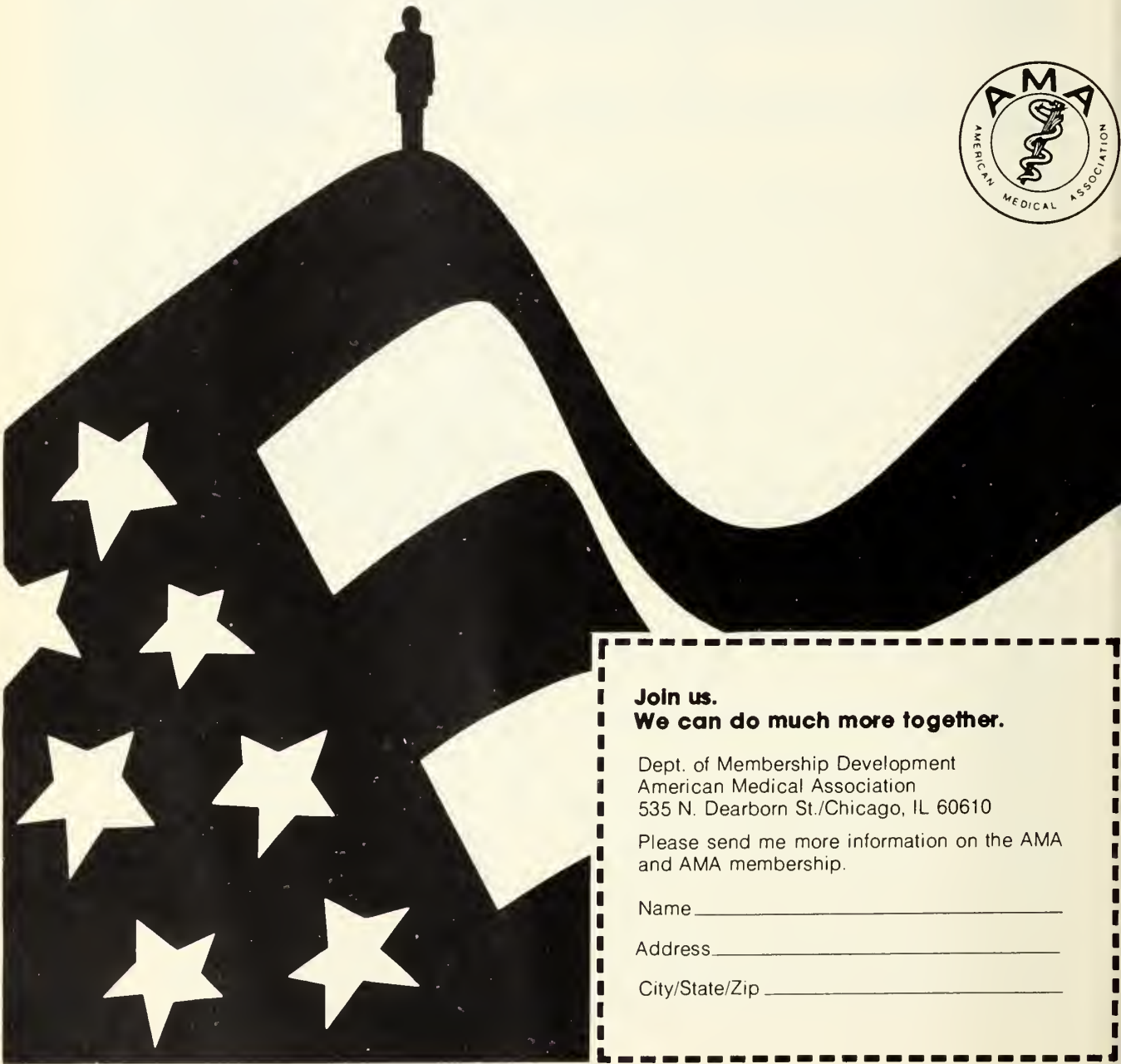
Medicine's men on the Hill

Just who are they? They're the AMA's permanent representatives to the Congress of the United States from the AMA's Washington office.

In every Congress about 10% of all legislation introduced is health related — some 2,500 bills and the number is increasing every year. The AMA lobbyists serve as the profession's eyes, ears, and voice on the Hill. Keeping in day-to-day contact with the members of Congress and their staffs. Explaining and promoting the profession's views. Reporting on legislation. And providing legislators with resource material and information on medical and health subjects.

They're on the Hill to protect your interests, lobbying to retain the basic freedoms of medical practice in any government health program that might be enacted. Equally important, they lobby to insure the passage of constructive and workable health legislation for the public.

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☐ Check if Official Delegate..... County

Scientific Exhibits 213th Annual Meeting

Policy—It is the policy of the Committee on Scientific Exhibits of the Medical Society of New Jersey—in instances where a pharmaceutical company has aided in the production of an exhibit either through financing or supplying products—that the trade name of the product or company is not to appear on any placards pertaining to the exhibit or on booth signs shown within the area of the exhibit, nor is it to appear in the description of the exhibit published in the program. However, the committee does not object to reprints or articles pertaining to the exhibit being distributed from the scientific exhibit booth, in which both generic and trade name should appear. Scientific exhibitors are free to discuss with visitors to their booths products used in their presentations.

Space assigned will be a drapery booth, consisting of a backwall and two sidewalls. Each booth is 6 feet deep. The backwall will vary according to the requirements of the exhibitor, and the measurements **must be** noted on the application.

All exhibits should be self-standing.

Please indicate on the application if a sign is incorporated within your exhibit. If so, one will **not** be ordered for you.

A **photograph** of the exhibit should accompany the application. If a photograph is not available, a **sketch** will suffice.

Application for Space in the Scientific Exhibits must be submitted no later than January 1, 1979 for consideration by the committee. Applications will be acted upon by the committee as soon after that date as possible and notification sent to all exhibitors. Send **completed** application, together with **photograph** or **drawing** of exhibit, to Mrs. Marion R. Walton, Convention Manager, the Medical Society of New Jersey, P.O. Box 904, Trenton, New Jersey 08605.

1. **TIME:** The Scientific Exhibits officially will open at 12:00 noon, Saturday, May 12, and will close at 3:00 p.m., Monday, May 14. Exhibits will be open on the intervening day from 9:00 a.m. to 5:00 p.m.

2. **INSTALLATION AND DISMANTLING:** Installation of exhibits may begin at 4:00 p.m., Friday, May 11, and all exhibits must be in place by 11:00 a.m., Saturday, May 12. Exhibits must remain intact until 3:00 p.m., Monday, May 14, and should be removed from the Exhibit Hall not later than 12:00 noon, Tuesday, May 15.

3. **COST:** The Society provides free of charge such space exhibitor may require, including booth, printed sign (if requested), and lights for illumination. The exhibitor must pay the cost of installing the exhibit, of renting tables, chairs, and for alterations and special construction, **including electrical connections**.

4. **SPONSORSHIP:** All exhibits must be shown in the name of individual persons. The name of the institution may appear as part of the address. Medical schools, hospitals, clinics, and other institutions and organizations should not present exhibits in their own names, but rather in the names of the individuals who worked up the exhibit.

5. **USE OF SPACE:** No exhibit shall interfere with another exhibit. No part of the exhibit will be allowed to extend above the top of the booth.

6. **AISLES:** Aisles must be kept clear; to this end exhibits must be so arranged that they will be inside the booth space.

7. **ADVERTISING:** No advertising matter of any description may be distributed, nor any material shown which in any way serves for commercial propaganda.

8. **DEMONSTRATIONS:** All exhibits must be in charge of competent, well-informed demonstrators. The worker who did the actual work shown, or someone who is familiar with all details, **must be present at all times during exhibit hours**.

9. **MOTION PICTURES:** Motion pictures may be shown in booths. Films are subject to preview at the discretion of the committee. They shall be non-inflammable, and **silent**. The exhibitor must supply his own screen, projector, and operator.

10. **LIABILITY:** It is agreed that exhibitors shall indemnify and hold blameless the Medical Society of New Jersey and Boardwalk Regency from all liability which may ensue from any cause whatsoever relating to the use of a booth by an exhibitor. Watchmen will be supplied, but MSNJ cannot guarantee exhibitors against loss. All valuable property should be insured by the exhibitor. MSNJ and the Committee on Annual Meeting, while permitting an exhibit, neither endorse nor assume any responsibility for the contents of such exhibit.

11. **AWARDS:** Exhibits will be judged on the basis of originality, excellence of correlating facts, and excellence of presentation.

12. **ADMISSION:** Admission to the Scientific Exhibits is by badge only. The general public is not admitted.

These regulations have become a part of the agreement between the exhibitor and the Medical Society of New Jersey. They have been formulated for the best interests of all concerned, and the cooperation of all exhibitors will be deeply appreciated.

Any points not covered are subject to settlement by the Medical Society of New Jersey and its Committee on Annual Meeting.

THE MEDICAL SOCIETY OF NEW JERSEY

213th ANNUAL MEETING

BOARDWALK REGENCY

ATLANTIC CITY, NEW JERSEY

APPLICATION FOR SPACE IN THE SCIENTIFIC EXHIBITS

MAY 12-14, 1979

The Committee on Annual Meeting will furnish uniform, painted signs for each exhibit—if requested by exhibitor. Please fill in the following form carefully. (use **typewriter**, or **print**, please)

1. TITLE (Generic names only): _____

Full Name and Degree of Exhibitor(s) _____

City _____ State _____

Institution (if desired) _____ City _____

Aided by commercial or pharmaceutical company _____

Exhibit constructed by: _____

2. DESCRIPTION OF EXHIBIT: (A brief description telling the purpose of the exhibit, what the exhibit shows, and the conclusions reached should be stated here. This is for publication in the printed program—use generic names only)

3. EXHIBIT is free-standing, self-contained: _____

4. SIGN will be required: _____ SIGN will NOT be required: _____

5. BACKWALL AND DIVIDERS will be required (see sketch on reverse): _____

6. SIZE OF BOOTH REQUESTED (see sketch on reverse) ABSOLUTE MAXIMUM: length 10', depth 8'.

Desired inside clear backwall (8 to 10 feet) _____ Minimum inside clear backwall _____

7. PHOTOGRAPH OR SKETCH of exhibit **should** accompany this application.

8. Has this exhibit been shown in whole or in part at any other scientific meeting? _____

If so, when? _____ and where? _____

The undersigned agrees to abide by the regulations listed.

Name _____

Address _____

Date: _____

Return application to MRS. MARION WALTON, Convention Manager, The Medical Society of New Jersey, P.O. Box 904, Trenton, New Jersey 08605.

(over)

COMPLETE ALL ITEMS ON BOTH SIDES OF FORM

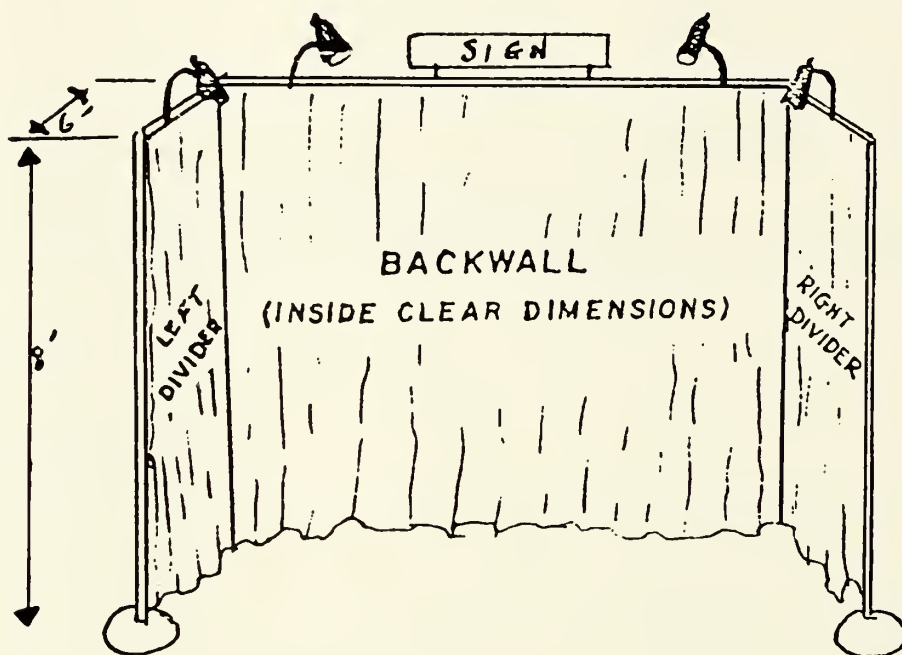
Standard Equipment Requisition Form

Use this form only in connection with equipment to be supplied by the Committee on Annual Meeting. Equipment listed below will be provided at no charge to exhibitors. However, it is important that you anticipate your exact requirements in advance, as last minute changes are costly to the Society.

All scientific booths will be erected with pipe and drapery backwall and dividers as illustrated below. Overhead lights are optional; however, the exhibitor **must** pay for electrical current supplied to booth.

ILLUSTRATION OF TYPICAL BOOTH

(Booth construction: blue bengaline drapery hung from polished aluminum tubing)



Check appropriate boxes: left divider backwall right divider

Overhead lights ☐ yes ☐ no ☐ yes ☐ no ☐ yes ☐ no

If your exhibit will not require backwall, or left or right drapery dividers, please advise.

If a sign is incorporated within your exhibit, please advise, and one will **not** be ordered for you.

COMPLETE ALL ITEMS ON BOTH SIDES OF FORM

PERSONAL ITEM

Dr. Cinotti Honored

Alfonse A. Cinotti, M.D., Newark ophthalmologist, was the recipient of the coveted Honor Award from the American Academy of Ophthalmology. The presentation was made on October 22 during the opening day of the Academy's annual five-day scientific conference. To qualify for the award an ophthalmologist must provide years of distinguished service, given freely, in any combination of media designated by the

Academy for the continuing education of fellow ophthalmologists. One point is awarded yearly for any of the following teaching services: instruction course, scientific paper, scientific exhibit, motion picture, continuing education course, continuing education program development, special scientific program, poster program, and clinical research forum. No more than two points are awarded in any one year; a physician must have accumulated ten points to be eligible for

the Award.

Currently President of the American Association of Ophthalmology, Dr. Cinotti is acting chairman of the Department of Ophthalmology, New Jersey Medical School, CMDNJ, and consultant on glaucoma to the New York Eye and Ear Infirmary. He is attending physician and director of both the Jersey City Medical Center and the Martland Medical Center in Newark.

LETTERS TO THE JOURNAL

Foreign Medical Graduates

Dear Editor:

The president of Camden County Medical Society, in a special memo to his members dated October 10, 1978, mentioned the following statement:

"Dr. Stanley Bergen, June 8, 1978—Memo to CMDNJ Board of Trustees.

"Development of regional residencies and replenishment of medical manpower in South Jersey faced with severe attrition, because of a high average physician's age and extreme dependence upon foreign medical graduates over the last few years, will grow from this center, which it is anticipated will be CMDNJ components."

Really I do not understand why Dr. Bergen is accusing South Jersey of having an extreme dependence upon foreign graduates. Is this an accusation for which South Jersey has to defend itself? Is it something that South Jersey is to be ashamed of? Are foreign medical graduates second-class physicians? If this is what Dr. Bergen means with his statement, allow me to disagree with him. Foreign medical graduates came to this country after they passed special examinations. All foreign medical grad-

uates have American training in any specialty they want and they went through the same examination for state or specialty board as any other American graduate. I do not want to go into details and mention the thousands of prominent and distinguished foreign medical graduates who hold high positions in the medical profession today.

The president of Camden County Medical Society in his answer tries to assure Dr. Bergen that South Jersey "does not have more dependence on foreign medical graduates than any other portion of New Jersey."

In other words the CCMS president agrees with Dr. Bergen that the problem of second-class physicians exists in South Jersey but no more than the rest of the state.

Being myself a foreign medical graduate, I am not ashamed, on the contrary, I am proud of it.

(signed) Theodore A. Lyras, M.D., P.A.

Dear Dr. Krosnick:

Thank you for sharing with me the letter of October 16, 1978 from Dr. Theodore A. Lyras. I believe the item to

which he refers is my memorandum of June 1, 1978 to the Board of Trustees, College of Medicine and Dentistry of New Jersey.

First, let me endorse Dr. Lyras' position in support of foreign medical graduates. I too have been impressed over the many years of teaching and, particularly, during the period of time that I was responsible for a large internal medicine residency program at a municipal hospital in Brooklyn, as to the quality of many foreign medical graduates and United States foreign medical graduates. The reference made in my memo to the Board of Trustees, which, unfortunately is taken out of context, was rather directed toward the future supply of foreign medical graduates for our state.

A recent article in *The Journal*, "Impact of the Health Professions Education Assistance Act of 1976 on Medical Manpower in New Jersey," by Mr. Cohen, *et al.* (October 1978), clearly brings into focus the problem that faces New Jersey. The severe limitation placed on the migration of foreign medical graduates and those foreign physicians who seek future educational opportunities in the United States, will compound the problems of New Jersey, particularly in reference to those coun-

ties who have, for whatever reason, depended upon foreign medical graduates for replenishing the attrition of health care manpower for their area. There was no implication in my memorandum to the Board of Trustees that foreign medical graduates represented a "second-class" category of physicians but, rather, I was stating the facts as health care manpower experts see the evolution of supply and demand of physicians for the next few years. I believe, contrary to the opinion of the President of the Camden County Medical Society, that the southern counties of our State have experienced a larger percentage of migration of foreign medical graduates than some other counties of the State. I also am aware that there are writers who have questioned the performance of both foreign medical graduates and United States citizens with a foreign medical education (*New England Journal of Medicine*, Volume 299, pages 855-862, October 19, 1978). However, neither of those observations was a part of my memorandum nor did I comment upon those matters in any context when considering the current issue before the College.

Once again, I reiterate my position concerning this matter: I firmly believe that the College of Medicine and Dentistry of New Jersey is a statewide educational institution which is responsible for providing educational opportunities

and programs to all segments of the state. The proper allocation of college resources includes serious consideration of the development of a full four-year medical school in South Jersey. This medical school, if developed, would serve as the focal point for not only clinical clerkship training in community hospitals, but also regional residency programs that could aid those same hospitals in the provision of health care, the support of practicing physicians and the development of a stable supply of health manpower, to fulfill future needs of the area involved. We must seek new solutions if, as mandated by the Federal Government, the source of foreign medical graduates is to be severely limited.

(signed) Stanley S. Bergen, Jr., M.D.
President, CMDNJ

Governor's Conference Papers

October 18, 1978

Dear Dr. Krosnick:

Many thanks for your recent letter and the copy of *The Journal*. (75:11, October 1978)

I was glad to have the opportunity to review the papers presented at the [Governor's] conference. With the

grants recently announced by Secretary Califano, the State will now have added fuel in our campaign against cancer.

Best wishes.

(signed) Governor Brendan Byrne

October 18, 1978

Dear Doctor Krosnick:

The excellent series of articles presented in the October 1978 issue of *The Journal* (pp. 740-774) related to cancer control and prevention in New Jersey deserves a hearty congratulations.

As Commissioner of the New Jersey State Department of Health and a colleague physician, I am delighted to observe the change in emphasis from treatment to prevention of cancer. It is indeed gratifying to share in this evolutionary process with medical professionals who have come to recognize the value of preventive medicine.

Medical care of malignant neoplasms, especially those related to occupation, may be significantly enhanced through creative utilization of preventive medicine techniques presently available. It shall continue to be the policy of the New Jersey State Department of Health uniformly to apply these techniques in an effort to stabilize and reduce the incidence of cancer morbidity and mortality in New Jersey.

(signed) Joanne E. Finley, M.D.

CME INFORMATION

Basic Sciences and Clinical Application

The Burlington County Memorial Hospital in Mount Holly has announced the following program in its series on basic sciences and clinical application. Sessions convene Thursdays at 3:30 p.m. on the dates indicated, in the conference center of the hospital. Each lecture meets the criteria for one credit hour in Category I of the AMA Physician's Recognition Award. For information please communicate with Dr. Robert W.

Parvin, Director of Medical Education at the hospital, 175 Madison Avenue, Mount Holly 08060.

Dec. 7 Hyperlipidemia
Dec. 14 "Small" Infections
Dec. 21 Senile Cataract

VA Medical Grand Rounds

The following program has been announced by the Pulmonary Disease Section of the Veterans Administration Hospital in East Orange. Sessions are held on Wednesdays on the dates in-

dicated at 11:30 a.m. in the third floor amphitheatre of the hospital. The first program, "Diagnostic Techniques in Pulmonary Diseases," was held on September 20.

December 20—Tracheobronchial Tree in Relation to Environmental Hazards: Oscar Auerbach, M.D., VA Hospital, East Orange

April 18—Thromboembolic Disease: Sol Sherry, M.D., Temple University School of Medicine

May 23—Interstitial Pulmonary Disease: Edward A. Gaensler, M.D., Boston University School of Medicine

Circulatory Disorders in the Elderly

The Kingsbrook Jewish Medical Center in Brooklyn has scheduled a conference on January 16 and 17 entitled, "Circulatory Disorders in the Elderly: Update for the Practicing Physician." The sessions will include subjects dealing with cerebrovascular, cardiac, and vascular disorders. Available also to those in attendance will be an audio-visual display on the stroke patient, which features frequent etiologies, clinical aspects, differential diagnosis, vascular pathology, latest diagnostic modalities, and current rehabilitative therapy of the stroke victim. The fee is \$55 which includes coffee, beverages, and buffet luncheon.

Eleven credit hours will be awarded in Category I of the AMA Physician's Recognition Award. Application has been made for the same number of credits from the AAFP and the American Osteopathic Association. For information and reservation please communicate with Morris Kleinfeld, M.D., Director, Kingsbrook Jewish Medical Center, Rutland Road and East 49th Street, Brooklyn 11203.

Gynecologic Endoscopy

On January 18 and 19, 1979, and again on June 14 and 15, the New Jersey Fertility Foundation will sponsor a course in gynecologic endoscopy. Accreditation will be given for 20 ACOG cognates and 13 hours in Category I of the AMA Physician's Recognition Award. For information please communicate with G. E. Laubach, M.D., 14 East Westfield Avenue, Roselle Park, New Jersey 07204.

Retraining Program for Inactive Physicians

The 1979 Spring and Fall retraining programs for inactive physicians have been announced by the Medical College of Pennsylvania. The first session is held from April 23 to June 15 and the deadline for applications is January 1st. Reservations for the Fall program (October 15 to December 8) must be received by July 1st. These are refresher courses in general medicine for physicians who wish to re-enter clinical medicine. Included is a review of physical diagnostic skills, experience in clinical rotations, a lecture series on general medicine,

pathophysiology, diagnosis, and patient management. This series has retrained more than 100 physicians, nearly all of whom have returned to active practice. For information and application please write to Mrs. C. M. Trulear, Program Administrator, Retraining Program for Inactive Physicians, Medical College of Pennsylvania, 3300 Henry Avenue, Philadelphia 19129—(215) 842-7118.

New Orleans Medical Assembly

The 42nd New Orleans Graduate Medical Assembly will be held April 27 to May 1, 1979 at The Fairmont in New Orleans. Theme for the scientific program is "Management of Common Problems in Office Practice—Update." Scientific and technical exhibits will be offered and several social events have been scheduled. Accreditation will be awarded in Category I of the Physician's Recognition Award and by the American Academy of Family Practice and the American Academy of Emergency Physicians. The registration fee for non-members is \$200; \$100 for physicians in military service; \$100 for registered nurses; interns, fellows, residents, and students may attend without charge. For detailed information, please communicate with Ms. Lois Neary, Executive Director, New Orleans Graduate Medical Assembly, 1430 Tulane Avenue, New Orleans, LA 70112.

CME Home Study Program

A self-assessment and home study program for physicians in primary care, under the caption of "Practice Related Educational Program (PREP)," is being offered through the Academy of Medicine of New Jersey. Designed by the College of Physicians of Philadelphia and endorsed by the Pennsylvania Medical Society, the Association for Hospital Medical Education, and the Medical Society of New Jersey, this activity, when completed as designed, meets the criteria for twenty credit hours per learning cycle in Category I of the Physician's Recognition Award of the AMA. Complete confidentiality is assured. One learning cycle consists of a practice profile as determined from completed practice survey forms for 100 patients, self-assessment of the selected learning area and receipt of a corrected answer sheet, selection of self-learning materials, post-learning self-assessment and receipt of corrected answers. For information

please communicate with the Academy of Medicine, 2424 Morris Avenue, Union, New Jersey 07083—(201) 687-8780.

Hypertension Volunteers Needed

The Squibb Institute for Medical Research is in need of volunteer hypertensive patients to participate in physician-supervised clinical studies. These studies require that patients aged 18 to 60 be institutionalized for up to 17 days at the Squibb Clinical Pharmacology Unit located at the Medical Center at Princeton. Participation includes a free complete physical examination, with results made available to the referring physician, if requested. Volunteers will be paid up to \$35 a day for each day they spend in the Unit, plus compensation for travel expenses. Physicians who have hypertensive patients interested in volunteering may communicate with Richard G. Devlin, Ph.D., Assistant Clinical Pharmacology Director, Squibb Institute for Medical Research, P.O. Box 4000, Princeton 08540—(609) 921-4866.

Vascular Society of New Jersey

A new specialty society, the Vascular Society of New Jersey, recently has been formed under the tutelage of the Academy of Medicine of New Jersey. Primary objectives of the society include (1) the establishment of standards of proficiency in the recognition and care of vascular diseases, (2) the promotion of adherence by the membership to these standards, (3) the enhancement and dissemination of education in vascular disease at the undergraduate, resident, graduate, and lay levels, (4) the encouragement of research in the etiology and modalities of treatment of vascular disease, and (5) the establishment of a registry of vascular disease.

Officers elected at the April 26th organizational meeting are:

President, Joseph Alpert, M.D., Millburn
President-Elect, Norman Rosenberg, M.D., Highland Park
Secretary, Robert Hobson, M.D., East Orange
Treasurer, Nicholas J. Demos, M.D., Short Hills
Directors, Adrian M. Sabety, M.D., East Orange; Adam R. Wychulis, M.D., Short Hills

Physicians interested in membership information may communicate with the Society's Executive Office, 2424 Morris Avenue, Union 07085—(201) 687-8780.

NEW YORK FERTILITY RESEARCH FOUNDATION, INC.

For the Investigation of Problems of Human Infertility

The Institute provides a complete diagnostic and consultation service for infertile couples. Investigations are conducted by well-known specialists in conjunction with consultants in the various fields of medicine related to infertility.

Patients are returned to the referring physician after appropriate studies have been made, together with a complete detailed report of the findings of the Institute and its consultants and recommendations for therapy. Literature on request.

123 East 89th Street, N.Y., N.Y. 10028

Phone: TR 6-9300

THE ENVIRONMENTAL SCIENCES LABORATORY
(DEPARTMENT OF COMMUNITY MEDICINE)

and

THE PAGE AND WILLIAM BLACK
POST-GRADUATE SCHOOL OF MEDICINE
of the MOUNT SINAI SCHOOL OF MEDICINE (CUNY)

Announce Postgraduate Courses

RECENT ADVANCES IN OCCUPATIONAL MEDICINE. Under the Direction of Irving J. Selikoff, M.D. and Faculty of the Mount Sinai School of Medicine. February 14, 15, 16, 1979, Wednesday, Thursday, Friday, 9:00 AM to 5:00 PM. Fee: \$250.

OCCUPATIONAL AND ENVIRONMENTAL LUNG DISEASE. Under the Direction of Irving J. Selikoff, M.D., Kaye H. Kilburn, M.D. and Faculty of the Mount Sinai School of Medicine. February 22, 23, 1979, Thursday and Friday, 9:00 AM to 5:00 PM. Fee: \$175.

MINI-RESIDENCY IN OCCUPATIONAL AND ENVIRONMENTAL MEDICINE. Under the Direction of Irving J. Selikoff, M.D., Harry Heimann, M.D., Arthur Frank, M.D., Ph.D., and Staff of The Environmental Sciences Laboratory. Two physicians each month; October through June. Fee: Four weeks \$650.

As an organization accredited for continuing medical education, The Page and William Black Post-Graduate School of Medicine of the Mount Sinai School of Medicine (CUNY) certifies that these continuing medical education offerings meet the criteria for Category I of the Physician's Recognition Award of the American Medical Association, provided they are used and completed as designed.

APPLY TO: Director, The Page and William Black Post-Graduate School of Medicine, Mount Sinai School of Medicine, One Gustave L. Levy Place, New York, New York, 10029. Tel.: (212) 650-6737.

THE DEPARTMENT OF PATHOLOGY
and
THE PAGE AND WILLIAM BLACK
POST-GRADUATE SCHOOL OF MEDICINE
of the MOUNT SINAI SCHOOL OF MEDICINE (CUNY)

Announce a Postgraduate Course

LABORATORY METHODS IN IMMUNOHEMATOLOGY AND BLOOD BANKING

Under the Direction of
RICHARD E. ROSENFELD, M.D. and STAFF

March 19-23, 1979

Monday through Friday, 9:00 AM to 5:00 PM (5 Sessions)

This course is intended for physicians who have the laboratory responsibility for immunohematological diagnosis and the safety of blood transfusions. Quantitative approaches to antigen and antibody studies are explored, and the relevance of such information to the problems of cellular survival in vivo are emphasized.

The course is divided into equal parts, one based primarily on enrollment performance, the other on seminar discussions of immunohematological and immunogenetic considerations in respect to the occurrence of clinical problems. Instrumental methods, including the Auto Analyzer, are included.

FEE: \$150

This course will be given at the Mount Sinai Medical Center, New York City, New York

APPLY TO: Director, The Page and William Black Post-Graduate School of Medicine, Mount Sinai School of Medicine, One Gustave L. Levy Place, New York, New York 10029. Tel.: (212) 650-6737.

THE DIVISION OF MEDICAL GENETICS of the
DEPARTMENT OF PEDIATRICS

and

THE PAGE AND WILLIAM BLACK
POST-GRADUATE SCHOOL OF MEDICINE
of the MOUNT SINAI SCHOOL OF MEDICINE (CUNY)

Announce a Postgraduate Course

ISSUES IN MEDICAL GENETICS

Under the Direction of
ROBERT J. DESNICK, Ph.D., M.D.

JOSHUA LEDERBERG, Ph.D., *Clara and William Kukin Memorial Lecturer, President of Rockefeller University; Nobel Laureate.*

With GUEST FACULTY AND FACULTY OF THE MOUNT SINAI SCHOOL OF MEDICINE

March 23, 1979—Friday—9:00 AM to 5:00 PM—(1 Session)

Fee: \$50. \$25 House Staff and Non-M.D.'s

*This course will be given at the Mount Sinai Medical Center,
New York City, New York*

APPLY TO: Director, The Page and William Black Post-Graduate School of Medicine, Mount Sinai School of Medicine, One Gustave L. Levy Place, New York, New York 10029. Tel.: (212) 650-6737.

CME CALENDAR

This listing is compiled through the cooperation of the Committee on Medical Education of the Medical Society of New Jersey, the Academy of Medicine of New Jersey, the New Jersey Chapter of the American Academy of Family Physicians, and the Office of Continuing Medical Education of the College of Medicine and Dentistry of New Jersey. For information on accreditation, please contact the sponsoring organization(s), indicated by italics — last line of each item.

ANESTHESIOLOGY

January

- 16 Dinner Meeting**
8-9 p.m.—Ramada Inn, Clark
(*NJ State Society of Anesthesiologists and AMNJ*)

February

- 24 Anesthesiology Presentations**
9 a.m.-1:30 p.m.—St. Barnabas Medical Center, Livingston
(*Educational Council for Anesthesiology of New Jersey and AMNJ*)

MEDICINE

(Includes Family, Internal, and General Medicine and Dermatology)

January

- 3 Advances in Medicine**
10 9:30-11 a.m.—Bergen Pines County
17 Hospital, Paramus
24 (*Bergen Pines County Hospital and*
31 *AMNJ*)

- 3 Immunology: Clinical**
10 **Peripheral Vascular Disorders**
17 **Biliary Problems**
24 **Granulomatous Diseases of the Bowel**
1-3 p.m.—Christ Hospital, Jersey City
(*Christ Hospital, AMNJ, and AAFP*)

- 3 Endocrinology—Dinner Meeting**
6:30-9:30 p.m.—Holiday Inn, East Orange
(*AMNJ Endocrinology Section*)

- 3 Grand Rounds and Case Presentations**
10 2-4 p.m.—Rotating between Martland,
17 Newark Beth Israel, St. Michael's, St.
24 Joseph's Hospitals, Newark
31 and Jersey City Medical Center
(*CMDNJ and AMNJ*)

- 3 Medical Grand Rounds**
11:30 a.m.—Rotates between Newark
Beth Israel Medical Center, Martland
Hospital, Newark, and VA Hospital,
East Orange
(*AMNJ Endocrinology Section*)

- 3 Endocrine Conferences**
10 3:30-5 p.m.—Rotates between Newark
17 Beth Israel Medical Center, Martland
24 Hospital, Newark, and VA Hospital,
31 East Orange
(*AMNJ Endocrinology Section*)

- 3 Clinical Enzymology**
10 **Chronic Complications of Diabetes**
17 **Common Hyperlipoproteinemias**
24 **Lower Gastrointestinal Bleeding**
31 **Patients with Major Burns**
9-11 a.m.—Riverview Hospital, Red
Bank
(*Riverview Hospital and AMNJ*)

- 4 Cardiology Conferences**
11 2:15-4:15 p.m.—Deborah Heart and
18 Lung Center, Browns Mills
25 (*Deborah Heart and Lung Center and*
AMNJ)

- 4 Grand Rounds and Case Presentations**
11 4-5 p.m.—Martland Hospital, Newark
18 (*CMDNJ and AMNJ*)
25

- 4 Arthritides**
11 **Rheumatic Fever**
18 **Surgery and Arthritis**
11:45 a.m.-12:45 p.m.—John F.
Kennedy Hospital, Edison
(*John F. Kennedy Hospital*)

- 4 Virology**
11 4-6 p.m.—Institute for Medical
18 Research, Copewood St., Camden
25 (*Institute for Medical Research and*
AMNJ)

- 5 Obesity**
8:30-9:30 a.m.—United Hospitals of
Newark
(*United Hospitals of Newark and AMNJ*)

- 9 Skin Infections**
8-10 p.m.—Schering Corporation,
Kenilworth
(*NJ Dermatological Society and AMNJ*)

- 9 Occlusive Vascular Disease**
8 p.m.—Paul Kimball Hospital,
Lakewood
(*Paul Kimball Hospital and AMNJ*)

- 9 Bleeding Diseases**
16 **Anemic Patient**
23 **Hepatitis**
11 a.m.-12 noon—Greystone Park
Psychiatric Hospital
(*Greystone Park Psychiatric Hospital and*
AMNJ)

- 10 Cerebral Vascular Disease**
1:30-2:30 p.m.—John E. Runnells
Hospital, Berkeley Heights
(*John E. Runnells Hospital and AMNJ*)

- 10 Nutrition Update**
9:30-11:30 a.m.—Dover General
Hospital
(*Riverside, Dover General, St. Claire's*
Hospitals and AMNJ)

- 16 Allergy and Immunology**
8-9 a.m.—Garden State Community
Hospital, Marlton
(*Garden State Community Hospital and*
AMNJ)

- 16 Hepatitis**
7-8 p.m.—Irvington General Hospital
(*Irvington General Hospital and AMNJ*)

- 17 Symposium: Diarrhea**
1-5 p.m.—Middlesex General Hospital,
New Brunswick
(*New Jersey Gastroenterological Society*
and AMNJ)

- 18 Regional Chest Conferences**
7:30-9:30 p.m.—Englewood Hospital
(*New Jersey Thoracic Society and*
AMNJ)

- 31 Cardiac Grand Rounds**
3-4:30 p.m.—CMDNJ-NJ Medical
School, Newark
(*American Heart Association and AMNJ*)

February

- 1 Cardiology Conferences**
8 2:15-4:15 p.m.—Deborah Heart and
15 Lung Center, Browns Mills
22 (*Deborah Heart and Lung Center and*
AMNJ)

- 1 Virology**
8 4-6 p.m.—Institute for Medical
15 Research, Copewood St., Camden
22 (*Institute for Medical Research and*
AMNJ)

- 2 Antiarrhythmic Medications**
9 **Hypertension Update**
16 **Radiology of the Heart—X-ray, Scan,**
and Echo

- 23 Differential Diagnosis of Heartblocks**
11:45-12:45 p.m.—John F. Kennedy
Hospital, Edison
(*John F. Kennedy Medical Center*)

- 7 Medical Grand Rounds**
11:30 a.m.—Rotates between Newark
Beth Israel Medical Center, Martland
Hospital, Newark, and VA Hospital,
East Orange
(*AMNJ Endocrinology Section*)

- 7 Dinner Meeting**
6:30-9:30 p.m.—Holiday Inn, East
Orange
(*AMNJ Endocrinology Section*)

- 7 Childhood Leukemia and Solid Tumors**
14 **Ulcer Disease**

- 21 Inflammatory Bowel Disease**
9-11 a.m.—Riverview Hospital, Red
(*Riverview Hospital and AMNJ*)

- 7 Environmental Hazards**
9:30-11:30 a.m.—Dover General
Hospital
(*Riverside, Dover General, St. Claire's,*
Denville and AMNJ)

- 7 Obesity**
11:30 a.m.-12:30 p.m.—Rahway
Hospital
(*Rahway Hospital and AMNJ*)

- 7 Advances in Medicine**
14 9:30 a.m.-11 a.m.—Bergen Pines County
21 Hospital, Paramus
28 (*Bergen Pines County Hospital and*
AMNJ)

- 7 Infertility**
10:30 a.m.-12 noon—St. Mary's

- Hospital, Passaic
(*St. Mary's Hospital and AMNJ*)
- 7 **Nephrology: Fluid and Electrolyte Imbalance**
- 14 **Physiological Parameters in Critical Care Therapy**
- 28 **Echocardiography**
1-3 p.m.—Christ Hospital, Jersey City
(*Christ Hospital, AMNJ, and AAFP*)
- 7 **Endocrine Conferences**
- 14 3:30-5 p.m.—Rotates between Newark
- 21 Beth Israel Medical Center, Martland
- 28 Hospital, Newark, and VA Hospital, East Orange
(*AMNJ Endocrinology Section*)
- 7 **Urinary Tract Infections**
- 14 **Blood Pressure and the Kidney**
- 21 **Diuresis and Antidiuresis**
- 28 **Diagnosis and Overdiagnosis of Digestive Disease**
9-11 a.m.—Middlesex General Hospital, New Brunswick
(*Middlesex General Hospital, AMNJ, and AAFP*)
- 13 **Clinical Immunology**
- 20 **Sepsis Shock**
11 a.m.-12 noon—Greystone Park Psychiatric Hospital
(*Greystone Park Psychiatric Hospital and AMNJ*)
- 13 **Acute and Chronic Hepatitis**
8 p.m.—Paul Kimball Hospital, Lakewood
(*Paul Kimball Hospital and AMNJ*)
- 13 **Allergy and Immunology**
8-9 a.m.—Garden State Community Hospital, Marlton
(*Garden State Community Hospital and AMNJ*)
- 13 **Bullous Diseases**
8-10 p.m.—Schering Corporation, Kenilworth
(*NJ Dermatological Society and AMNJ*)
- 13 **Cardiac Rehabilitation**
12:45-2 p.m.—Helene Fuld Medical Center, Trenton
(*American Heart Association, Mercer County Chapter*)
- 14 **Blood Gases**
1:30-2:30 p.m.—John E. Runnells Hospital, Berkeley Heights
(*John E. Runnells Hospital and AMNJ*)
- 15 **Impact of Genetics on Medical Practice**
5-6:30 p.m.—Somerset Hospital, Somerville
(*Somerset Hospital and AMNJ*)
- 15 **Regional Chest Conferences**
7:30-9:30 p.m.—St. Michael's Medical Center, Newark
(*New Jersey Thoracic Society and AMNJ*)
- 20 **Use and Abuse of Antibiotics**
8 p.m.—Holy Name Hospital, Teaneck
(*Holy Name Hospital and AMNJ*)
- 20 **Infectious Diseases—Endotoxic Shock**
7-8 p.m.—Irvington General Hospital
(*Irvington General Hospital and AMNJ*)
- 28 **Cardiac Grand Rounds**
3-4:30 p.m.—CMDNJ-NJ Medical School
(*American Heart Association and AMNJ*)

NEUROLOGY/PSYCHIATRY

January

- 2 **Seminar on Law and Psychiatry**

- 9 3:30-5:30 p.m.—Rutgers Law School, Newark
- 23 (*Rutgers University Law School and AMNJ*)
- 30 **Psychopharmacology Update**
- 17 **Epilepsy and Convulsive Disorders**
- 31 **Psychosomatic Medicine**
1-3 p.m.—Ancora Psychiatric Hospital, Hammonton
(*Ancora Psychiatric Hospital and AMNJ*)
- 3 **Seizure Disorders**
- 31 **Congenital Diseases**
10:30 a.m.-12 noon—St. Mary's Hospital, Passaic
(*St. Mary's Hospital and AMNJ*)
- 4 **Psychotherapeutic Techniques**
8-10 p.m.—312 Harding Drive, South Orange
(*Group for Advanced Psychiatric Study and AMNJ*)
- 4 **Psychiatric Lecture Series**
- 11 11 a.m.-12 noon—Greystone Park
- 18 Psychiatric Hospital
- 25 (*Greystone Park Psychiatric Hospital and AMNJ*)
- 8 **Psychiatric Lecture Series**
8-10 p.m.—111 Ridgewood Ave., Glen Ridge
(*Essex Psychiatric Seminar and AMNJ*)
- 8 **Neuroscience Conferences**
- 15 11:30 a.m.-12:30 p.m.—Bergen Pines
- 22 County Hospital, Paramus
- 29 (*Bergen Pines County Hospital and AMNJ*)
- 9 **Early Childhood Treatment Services**
8-10 p.m.—Ramada Inn, Clark
(*New Jersey Council of Child and Adolescent Psychiatry and AMNJ*)
- 10 **Depression in the Community**
- 24 **Child Psychology**
1:30-3 p.m.—NJ Medical School, Newark
(*NJ Medical School and AMNJ*)
- 10 **Alcoholism**
11:30 a.m.-12:30 p.m.—Rahway Hospital
(*Rahway Hospital and AMNJ*)
- 10 **Cerebral Vascular Disease**
1:30-2:30 p.m.—John E. Runnells Hospital, Berkeley Heights
(*John E. Runnells Hospital and AMNJ*)
- 11 **Psychogeography: Analytic Outline of a New Science**
8:30-10:30 p.m.—Hackensack Hospital
(*Hackensack Hospital and AMNJ*)
- 16 **Seizure Disorders**
11:30 a.m.-12:30 p.m.—St. Mary's Hospital, Orange
(*St. Mary's Hospital and AMNJ*)
- 17 **Addictive Personality: Drug and Alcohol Dependence**
- 24 **Drug Therapy in Psychiatric Disorders of Older Patients**
- 31 **Acute and Chronic Alcoholism in Clinical Patients**
9 a.m.-11 a.m.—Middlesex General Hospital, New Brunswick
(*Middlesex General Hospital, AMNJ, and AAFP*)
- 17 **Thanatology**
1-2 p.m.—Trenton Psychiatric Hospital
(*Trenton Psychiatric Hospital and AMNJ*)
- 23 **Alcoholism**
8-9 p.m.—Warren Hospital, Phillipsburg
(*Warren Hospital and AMNJ*)

- 27 **Annual Meeting**
9 a.m.-4 p.m.—Buck Hill Inn, Buck Hill, Pa.
(*NJ Psychiatric Association and AMNJ*)

February

- 1 **Psychotherapeutic Techniques**
8-10 p.m.—312 Harding Drive, South Orange
(*Group for Advanced Psychiatric Study and AMNJ*)
- 1 **Psychiatric Lecture Series**
- 8 11 a.m.-12 noon—Greystone Park
- 15 Psychiatric Hospital
- 22 (*Greystone Park Psychiatric Hospital and AMNJ*)
- 5 **Intermittent Treatment of a Schizophrenic**
8-10 p.m.—39 Crescent Ave., Passaic
(*Essex Psychiatric Seminar and AMNJ*)
- 5 **Neuroscience Conferences**
- 12 11:30 a.m.-12:30 p.m.—Bergen Pines
- 19 County Hospital, Paramus
- 26 (*Bergen Pines County Hospital and AMNJ*)
- 6 **Headache**
8-9 p.m.—Burdette Tomlin Memorial Hospital, Cape May Court House
(*Burdette Tomlin Memorial Hospital and AMNJ*)
- 6 **Seminar on Law and Psychiatry**
13 3:30-5:30 p.m.—Rutgers Law School, Newark
- 20 (*Rutgers University Law School and AMNJ*)
- 7 **Depression**
- 21 Title to be announced
1:30-3 p.m.—NJ Medical School, Newark
(*NJ Medical School and AMNJ*)
- 7 **Psychosomatic Medicine**
- 14 **Hospital Psychiatry—Principles**
- 21 **Hospital Psychiatry—Treatment**
1-3 p.m.—Ancora Psychiatric Hospital, Hammonton
(*Ancora Psychiatric Hospital and AMNJ*)
- 8 **Voice of Conscience**
8:30-10:30 p.m.—Location to be announced
(*NJ Psychoanalytic Society and AMNJ*)
- 21 **Addicts**
1-2 p.m.—Trenton Psychiatric Hospital
(*Trenton Psychiatric Hospital and AMNJ*)
- 22 **Voice of Conscience**
8:30-10:30 p.m.—St. Barnabas Medical Center, Livingston
(*New Jersey Psychoanalytic Society and AMNJ*)
- 28 **Ischemic Brain Syndromes**
9-11 a.m.—Riverview Hospital, Red Bank
(*Riverview Hospital and AMNJ*)

OBSTETRICS/GYNECOLOGY

January

- 3 **Drugs and Pregnancy**
9-11 a.m.—Middlesex General Hospital, New Brunswick
(*Middlesex General Hospital, AMNJ, AAFP*)
- 3 **Grand Rounds and Case Presentations**
- 10 2-4 p.m.—Rotating between Martland
- 17 Hospital, Newark, Newark Beth Israel,
- 24 St. Michael's, Newark, St. Joseph's,

31 Paterson, and Jersey City Medical Centers
(*CMDNJ—New Jersey Medical School and AMNJ*)

4 **Grand Rounds and Case Presentations**
11 4-5 p.m.—Martland Hospital, Newark
18 (*NJ Medical School and AMNJ*)
25

9 **Vaginal Bleeding**
11:45 a.m.-12:45 p.m.—John F. Kennedy Hospital, Edison
(*John F. Kennedy Hospital*)

10 **Endometrial Carcinoma**
8-9 a.m.—Garden State Community Hospital, Marlton
(*Garden State Community Hospital and AMNJ*)

18 **Breast Cancer**
5-6:30 p.m.—Somerset Hospital, Somerville
(*Somerset Hospital and AMNJ*)

February

1 **Grand Rounds and Case Presentations**
8 4-5 p.m.—Martland Hospital, Newark
15 (*NJ Medical School and AMNJ*)
22

7 **Infertility**
10:30 a.m.-12 noon—St. Mary's Hospital, Passaic
(*St. Mary's Hospital and AMNJ*)

7 **Grand Rounds and Case Presentations**
14 2-4 p.m.—Rotating between Martland Hospital, Newark, Newark Beth Israel, St. Michael's, Newark, St. Joseph's Hospital, Paterson and Jersey City Medical Centers
(*New Jersey Medical School and AMNJ*)

14 **Toxemia of Pregnancy**
11:45 a.m.-12:45 p.m.—John F. Kennedy Hospital, Edison
(*John F. Kennedy Hospital*)

14 **The Laboratory in Gynecology**
8-9 a.m.—Garden State Community Hospital, Marlton
(*Garden State Community Hospital and AMNJ*)

20 **Breast Cancer**
11:30 a.m.-12:30 p.m.—St. Mary's Hospital, Orange
(*St. Mary's Hospital and AMNJ*)

PATHOLOGY/CLINICAL PATHOLOGY

January

3 **Clinical Pathology Grand Rounds**
10 12 noon-1 p.m.—NJ Medical School, Newark
17 (*NJ Medical School and AMNJ*)
24
31

24 **Neuropathology Conferences**
8-9:15 a.m.—NJ Medical School, Newark
(*NJ Medical School and AMNJ*)

February

7 **Clinical Pathology Grand Rounds**
14 12 noon-1 p.m.—NJ Medical School, Newark
21 (*NJ Medical School and AMNJ*)
28

14 **Blood Gases**
1:30-2:30 p.m.—John E. Runnells Hospital, Berkeley Heights
(*John E. Runnells Hospital and AMNJ*)

27 **Laboratory Interpretations**
11 a.m.-12 noon—Greystone Park

Psychiatric Hospital
(*Greystone Park Psychiatric Hospital and AMNJ*)

28 **Neuropathology Conferences**
8-9:15 a.m.—NJ Medical School, Newark
(*NJ Medical School and AMNJ*)

PEDIATRICS

January

5 **Advances in Pediatrics**
12 9:30-10:30 a.m.—NJ Medical School, Newark
19 (*NJ Medical School and AMNJ*)
26

9 **Early Childhood Treatment Services**
8-9 p.m.—Ramada Inn, Clark
(*NJ Council of Child and Adolescent Psychiatry and AMNJ*)

10 **Adolescent Health Care**
9-11 a.m.—Middlesex General Hospital, New Brunswick
(*Middlesex General Hospital, AMNJ, and AAFP*)

24 **Child Psychology**
1:30-3 p.m.—NJ Medical School, Newark
(*NJ Medical School and AMNJ*)

February

2 **Advances in Pediatrics**
9 9:30-10:30 a.m.—NJ Medical School, Newark
16 (*NJ Medical School and AMNJ*)
23

7 **Childhood Leukemia and Solid Tumors**
9-11 a.m.—Riverview Hospital, Red Bank
(*Riverview Hospital and AMNJ*)

15 **Impact of Genetics on Medical Practice**
5-6:30 p.m.—Somerset Hospital, Somerville
(*Somerset Hospital and AMNJ*)

RADIOLOGY

January

11 **Ultrasound Case Presentations**
7:30-9:30 p.m.—Location to be announced
(*NJ Institute of Ultrasound in Medicine and AMNJ*)

17 **Radiotherapy Section Dinner Meeting**
6:30-8:30 p.m.—The Manor, West Orange
(*AMNJ*)

18 **Aneurysms of the Aorta**
7:15-10:15 p.m.—Hospital Center at Orange
(*Diagnostic Radiology Section for Northern NJ and AMNJ*)

25 **X-ray of the Spine**
11:45 a.m.-12:45 p.m.—John F. Kennedy Hospital, Edison
(*John F. Kennedy Hospital*)

February

8 **Ultrasound Case Presentations**
7:30-9:30 p.m.—Location to be announced
(*NJ Institute of Ultrasound in Medicine and AMNJ*)

16 **Radiology of the Heart—X-ray, Scan, Echo**
11:45 a.m.-12:45 p.m.—John F. Kennedy Hospital, Edison
(*John F. Kennedy Hospital*)

27 **Ultrasound Diagnosis**
8-10 p.m.—Englewood Club, Englewood
(*Englewood Surgical Society and AMNJ*)

SURGERY

(General)

January

8 **Lecture Series in Surgery**
15 4:30-5:30 p.m.—NJ Medical School, Newark
21 (*NJ Medical School and AMNJ*)
28

9 **Lower Limb Grafting Procedures**
8-9 a.m.—Paterson General Hospital
(*Paterson General Hospital and AMNJ*)

18 **Surgery and Arthritis**
11:45 a.m.-12:45 p.m.—John F. Kennedy Hospital, Edison
(*John F. Kennedy Hospital*)

18 **Breast cancer**
5-6:30 p.m.—Somerset Hospital, Somerville
(*Somerset Hospital and AMNJ*)

18 **Aneurysms of the Aorta**
7:15-10:15 p.m.—Hospital Center at Orange
(*Diagnostic Radiology Section for Northern NJ and AMNJ*)

22 **Head and Neck Tumors**
7:45-9 a.m.—Newark Beth Israel Medical Center
(*Newark Beth Israel Medical center and AMNJ*)

23 **Hemostasis for Surgeons**
8-10 p.m.—Englewood Club, Englewood
(*Englewood Surgical Society and AMNJ*)

February

5 **Lecture Series in Surgery**
12 4:30-5:30 p.m.—NJ Medical School, Newark
19 (*NJ Medical School and AMNJ*)
26

20 **Breast Cancer**
11:30 a.m.-12:30 p.m.—St. Mary's Hospital, Orange
(*St. Mary's Hospital and AMNJ*)

21 **Rehabilitation Surgery**
1-3 p.m.—Christ Hospital, Jersey City
(*Christ Hospital, AMNJ, and AAFP*)

SURGICAL SPECIALTIES

(Includes ENT, neurosurgery, ophthalmology, orthopedics, plastic, and vascular surgery)

January

4 **Neurosurgical Case Presentations**
11 4-5:30 p.m.—NJ Medical School, Newark
18 (*NJ Medical School and AMNJ*)
25

5 **Diagnostic and Therapeutic Problems in Orthopedics**
12 7:30-9 a.m.—Alexian Brothers Hospital, Elizabeth
26 (*Alexian Brothers Hospital*)

9 **Lower Limb Grafting Procedures**
8-9 a.m.—Paterson General Hospital
(*Paterson General Hospital and AMNJ*)

22 **Head and Neck Tumors**
7:45-9 a.m.—Newark Beth Israel Medical Center
(*Newark Beth Israel Medical Center and AMNJ*)

February

1 **Neurosurgical Case Presentations**

- 8 4-5:30 p.m.—NJ Medical School,
15 Newark
22 (*NJ Medical School and AMNJ*)
2 **Head and Neck Cancer**
8:30-9:30 a.m.—United Hospitals of
Newark
(*United Hospitals of Newark and AMNJ*)
2 **Diagnostic and Therapeutic Problems in**

- 9 **Orthopedics**
23 7:30-9 a.m.—Alexian Brothers Hospital,
Elizabeth
(*Alexian Brothers Hospital*)

MISCELLANEOUS

- January
31 **Sports Medicine: Common Injuries**

1-3 p.m.—Christ Hospital, Jersey City
(*Christ Hospital, AMNJ, and AAFP*)

February

- 27 **Malpractice**
8-9 p.m.—Warren Hospital, Phillipsburg
(*Warren Hospital and AMNJ*)

THE SECOND ANNUAL EDWARD G. WATERS GYNECOLOGIC CONFERENCE

Presented by the Department of Obstetrics and
Gynecology
of the New Jersey Medical School — CMDNJ
at the Playboy Club Resort Hotel

featuring:

- A "SEXUAL COUNSELLING WORKSHOP"
on MARCH 1st, 1979 and
"CONTROVERSIES IN GYNECOLOGY"
on MARCH 2nd-4th, 1979

For further information please contact Herik Caterini,
M.D., Department of Obstetrics and Gynecology,
New Jersey Medical School, 65 Bergen Street, New-
ark, New Jersey 07107.

(201) 643-0407 or (201) 456-4223

EDUCATIONAL CREDITS:

	Sexual Counselling Workshop-March 1	Controversies in Gynecology March 2-4
AMA Credits Category I:	5	21
ACOG Cognates:	6	17
AAFP Prescribed Credits:	8	20
American Osteopathic Association:	5	16
New Jersey Nurses Association:	6	17.5

WEEKLY CARDIOLOGY CONFERENCES

(Approved for 2 hours Cot. I Credit for C.M.E.)

Objective of Program: Update of diagnostic methods on
cardiology; indications and results of cardiac surgery.

PROGRAM CHAIRMAN: Harry Goldberg, M.D., Professor of
Medicine
Temple University School of Medicine
Chief of Cardiology, Deborah Heart
and Lung Center

With specialists on Deborah's staff presenting Echocardiograms,
ECG's, Treadmill testing, Vector-Cardiograms, Nuclear Scans,
Coronary Cines and Ventriculograms, Cardiac Cath. Data,
Angiograms and Surgical Methods.

Guest Lecturers: A distinguished guest lecturer will present
special topics on Cardiology once a month.

THURSDAYS (Every Week) 2:15 P.M.—4:00 P.M. (September 7,
1978 to June 28, 1979)

LOCATION: DEBORAH HEART AND LUNG CENTER,
BROWNS MILLS
(1st. Floor Conf. Room)

OBITUARIES

Dr. Ernest Bacote

Ernest Bacote, M.D., who practiced general medicine in Newark for almost fifty years, died in St. Michael's Hospital, Newark, on September 17th. A native of South Carolina, Dr. Bacote was graduated from Howard University Medical School in 1926 and came to Newark two years later to establish a family practice which he maintained until retirement in 1975. He had been affiliated with Beth Israel Hospital there, and was involved actively with the Venereal Disease Division of the Newark Department of Health. Dr. Bacote was 78 years old at the time of his death.

Dr. Samuel J. Berenson

One of Union County's senior members, Samuel J. Berenson, M.D., died on September 29 at his home. A graduate of New York University School of Medicine, class of 1931, Dr. Berenson pursued a career in general surgery. He was a Fellow of the American College of Surgeons and of the International College of Surgeons and had been attending surgeon at Alexian Brothers and St. Elizabeth's Hospitals. During World War II, Dr. Berenson served as an officer in the medical department of the Army of the United States. He was 74 years old at the time of his death.

Dr. Ames L. Filippone

Word has just been received of the death on August 9 in Fort Lauderdale, Florida, of Ames L. Filippone, M.D., a member of our Essex County component. Born in 1896 and graduated from Albany Medical College, class of 1922, Dr. Filippone practiced general medicine in Newark for many years, retiring to Florida in 1974. He had been affiliated with Presbyterian and Columbus Hospitals. Dr. Filippone was the recipient of MSNJ's Golden Merit Award, denoting fifty years of medical practice, in 1972.

Dr. Benjamin F. Slobodien

At the grand age of 87, Benjamin F. Slobodien, M.D., one of Middlesex County's renown physicians, died on October 23. A native of New Jersey, Dr. Slobodien earned his medical degree from the old Bellevue Medical College in 1913 and pursued a career in general surgery. He had been director of surgery and chief of that department at Perth Amboy General Hospital, and was affiliated also with the Jewish Rehabilitation Hospital in North Brunswick, Roosevelt Hospital in Metuchen, and the J. F. Kennedy Hospital in Edison. He was a Fellow of the American College of Surgeons. Dr. Slobodien had been president of his county medical society in 1940 and on the state level served several terms as a member of Committee on Medical Defense and Insurance. He received MSNJ's Golden Merit Award, indicating fifty years of practice, in 1963. Dr. Slobodien was active on the Board

of Health of Perth Amboy and served a term as its president. A son, Dr. Howard Slobodien, is a practicing physician in Perth Amboy and a member of MSNJ's Board of Trustees.

Dr. Joseph C. Vargyas

One of Middlesex County's well-known practitioners, Joseph C. Vargyas, M.D., died on September 30th. Born in Jersey City in 1912, Dr. Vargyas earned his doctorate of medicine from George Washington University Medical School, class of 1939, and returned to New Jersey to pursue a career in general and gynecologic surgery. He was on the staff at both St. Peter's and Middlesex General Hospitals in New Brunswick. Dr. Vargyas was a member of the American Society of Abdominal Surgeons.

Dr. F. Rolfe Westney

We have just learned of the death on August 21 of F. Rolfe Westney, M.D., a member of our Atlantic County component. A native of New Jersey, born in 1899, Dr. Westney earned his medical degree from Hahnemann Medical College in 1926 and practiced general medicine in the Atlantic City area until a chronic heart ailment forced his retirement in the early 1970s. He had been affiliated with the Atlantic City Medical Center.

BOOK REVIEWS

Basic and Clinical Immunology

Second Edition. Fudenberg, Stites, Caldwell and Wells. Los Altos, California, Lange, 1978. Pp. 758. Illustrated (\$14.50)

In this 2nd Edition, the writers succinctly have covered the essentials of basic and clinical immunology as known in 1978. The fundamentals of immunochemistry and immunobiology are described clearly and simply in the first section (138 pages); the second section shows how this knowledge is applied to immunobiology (196 pages). Next is detailed the current immunological laboratory tests available (53 pages); and the final section shows how many human disorders clearly have an immunopathological basis.

The authors have written interesting and illuminating chapters on such fields of medicine as rheumatic disease, hematological disease, allergic disease, gastrointestinal and liver disease, renal disease, dermatological disease, infectious disease, endocrine disease, neurological disease, and oral and dental disease—all in 367 pages. These topics are covered from their immunological aspects—not as complete medical texts on each disease. There is an excellent chapter on immunizations against infectious disease.

This textbook is a valuable addition to our understanding of the whole field of immunology and an excellent review for immunologists, as well as a useful up-to-date text for both students and practicing physicians. It is highly recommended. All 52 of the contributing authors are to be congratulated and ex-

pecially the four editors. There is a thorough index and useful glossary on commonly used acronyms, abbreviations, and immunological terms.

Arthur A. Goldfarb, M.D.

General Urology.

Ninth Edition. Donald R. Smith, M.D. Los Altos, California, Lange, 1978. Pp. 541. Illus. (\$14.50)

In this new, ninth edition Dr. Donald Smith, Professor of Urology at Rutgers Medical School, has compiled the entire field of urology into one clear concise volume. Divided into 35 chapters the book begins with the anatomy and embryology of the urinary tract, with chapters on all the urinary tract organs, and includes expanded material on ultrasonic examination, immunology, and neuropathic bladder disorders. Each chapter is subdivided into useful sections such as etiology, pathogenesis, staging, symptoms, signs, laboratory and x-ray findings, differential diagnosis, and treatment. The volume is organized superbly and contains a wealth of factual information.

While originally written for the medical student and the non-urologist, the book gives a clear summary of both basic and recent urological information and is just as valuable to the specialist. It is very helpful in organizing one's material for lectures and checking for completeness. Dr. Smith personally has written nineteen of the chapters; Dr. Emil Tanagho prepared five chapters.

A current, well-written and well-organized review of the entire field of urology, this book is an ideal addition to

the library of the generalist, the nephrologist, and the urologist.

Robert H. Stackpole, M.D.

Current Obstetric and Gynecologic Diagnosis and Treatment

Ralph C. Benson. Los Altos, California, Lange, 1978. Pp. 976. Illus. (\$18—soft-back)

This volume is a distillate of most of the present knowledge in obstetrics and gynecology. The format provides a clear and concise source for reviewing the most current thought concerning obstetric and gynecologic diagnosis and treatment. As such it serves as an excellent guide for the resident or practitioner who wishes to look up or to review a current case.

As in any text with multiple contributors, there is some overlap of material and difference in style. Overall, Dr. Benson exhibits tight editorial control over the forty-three chapters.

That the bladder should be drained by catheterization prior to the use of elective low forceps probably is not the consensus of most obstetricians. Likewise, use of a vacuum extractor in placenta previa would raise some eyebrows.

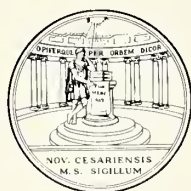
Major advantages of the book are its currentness and its moderate price. The small type remains a constant reminder that one is not getting any younger.

I recommend it for the desk of the physician caring for women.

Gerard F. Hansen, M.D.

THE JOURNAL OF THE MEDICAL SOCIETY OF NEW JERSEY

Index



1978

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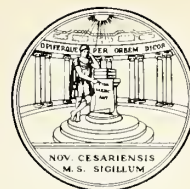
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1977 Transactions

At its first session on Saturday, May 6, 1978, the House of Delegates approved the Transactions of the 1977 House of Delegates as published in the July 1977 issue of *The Journal*, with the exception of the recorded action concerning a reference committee amendment to Chapter VI (a) of the Bylaws (see pages Tr54 and Tr127, July 1977 JMSNJ) which precluded election as an AMA Delegate or Alternate Delegate after age 65. The Board of Trustees accepted the majority opinion (three of five members) of a committee appointed by the Board to review the transcript concerning the disputed action, which was that the suggested amendment to the Bylaws was not adopted by the House. A motion from the floor to approve the action of the Board of Trustees was accepted by the House.

Action To Limit Debate

At its first session on Saturday, May 6, 1978, the House of Delegates agreed, upon motion, that no one may speak more than once on any given subject except in rebuttal or by express permission of the House, and that floor time in each instance shall be limited to four (4) minutes unless exception is made by the House.

Reports and resolutions, and the actions thereon, are included under the Reference Committee to which they were assigned.

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212th ANNUAL MEETING

The Medical Society of New Jersey

May 6-9, 1978

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Smoking — Resolution #16	"G"	Tr 80
Spring and Fall Conferences	"A"	Tr 13
Surplus Payment, Deductibility of (Board of Trustees' item)	"C"	Tr 35
Temporary Licensure of Physicians (Board of Trustees' item)	"A"	Tr 13
Transactions, 1977 House of Delegates		Tr 2
Treasurer	"B"	Tr 20
Trustees, Board of	"A"	Tr 12
Unlicensed Physicians Practicing in State Hospitals (Board of Trustees' item)	"A"	Tr 13

MEMORIAL RESOLUTIONS

The following resolutions were received by the House with sorrowful concurrence.

Elton W. Lance, M.D. 1898-1978

Whereas, Almighty God has summoned from our midst our beloved colleague, Elton W. Lance, M.D.; and

Whereas, as a Fellow and Officer of the Medical Society of New Jersey, Doctor Lance served the people of New Jersey and the Medical Society of New Jersey; and

Whereas, by his dependability and consideration he won the esteem of all who knew him; now therefore be it

RESOLVED, that the Medical Society of New Jersey, honoring Elton W. Lance, M.D., in death as in life, records its profound grief at his passing; and be it further

RESOLVED, that a copy of this Resolution be spread upon the minutes of this meeting and that another copy, suitably prepared, be presented to his bereaved family in token of heartfelt sympathy.

Harrold A. Murray, M.D. 1893-1977

Whereas, Almighty God has summoned from our midst His good servant and our beloved colleague, Harrold A. Murray, M.D.; and

Whereas, as a Fellow, Officer, and member of the Medical Society of New Jersey, Doctor Murray rendered uniformly high and valuable service to this Society and the people of our State; and

Whereas, by his understanding, dependability, and concern he won the admiration of all who knew him; now therefore be

it

RESOLVED, that the Medical Society of New Jersey honoring Harrold A. Murray, M.D., in death as in life, records its grief at his passing; and be it further

RESOLVED, that a copy of this Resolution be spread upon the minutes of this meeting and that another copy, suitably prepared, be presented to his bereaved family in token of heartfelt sympathy.

I. Edward Ornaf, M.D. 1908-1978

Whereas, the Supreme Author has summoned from our midst his good servant and our beloved colleague, I. Edward Ornaf, M.D.; and

Whereas, as a Trustee and Officer of the Medical Society of New Jersey, and a Member of the State Board of Medical Examiners he rendered valuable services to the medical profession and the people of New Jersey; and

Whereas, by his dedication and sincerity he consistently reflected credit upon the Medical Society of New Jersey; now

therefore be it

RESOLVED, that the Medical Society of New Jersey record its lasting indebtedness to I. Edward Ornaf, M.D., and its heartfelt grief at his passing; and be it further

RESOLVED, that this Resolution be spread upon the minutes of this meeting and that a copy, suitably prepared, be presented to his bereaved widow and family in token of our sympathy.

REFERENCE COMMITTEE ON CONSTITUTION AND BYLAWS

Robert S. Rigolosi, M.D., Bergen
Chairman
Myles C. Morrison, M.D., Morris
Nicholas E. Marchione, M.D., Cumberland
Paul J. Kreutz, M.D., Union
Ralph J. Fioretti, M.D., Bergen
Richard H. DePree, M.D., Gloucester
Alternate Member

Reports:
Committee on Revision of
Constitution and Bylaws
Amendments to Bylaws

Revision of Constitution and Bylaws

Hillel M. Ben-Asher, M.D., Chairman, Morristown

(Reference Committee on Constitution and Bylaws)

The Committee on Revision of Constitution and Bylaws met on March 1, 1978, at the Executive Offices in Trenton. The Committee considered the various items before it and its unanimous actions are reflected in the following report:

BYLAWS

Chapter VI—Other Delegates and Representatives

Delegates and Alternate Delegates to other medical organizations shall be elected in accordance with the provisions of these Bylaws.

(a)—American Medical Association

Current

The terms of office of Delegates and Alternate Delegates shall begin on January first of the year following their election, and shall continue for two (2) years, ending on the second December 31 thereafter.

In the absence of any Delegate, any Alternate Delegate shall be eligible to serve.

No member shall serve more than three two-year terms as an AMA Delegate. Likewise, no member shall serve more than three two-year terms as an Alternate Delegate.

Proposed

The term of office of Delegates and Alternate Delegates shall begin on January first of the year following their election, and shall continue for two (2) years, ending on the second December 31 thereafter.

In the absence of any Delegate, any Alternate Delegate shall be eligible to serve.

Delete

Not Adopted

This proposal was received from the Mercer County Medical Society and would allow AMA Delegates and Alternates unlimited tenure. The House of Delegates has considered this topic at least three times since 1972 and each time voted emphatically for limited tenure.

The Committee on Revision of Constitution and Bylaws recommends that this proposal not be adopted.

Approved

The proposal was not adopted in accordance with the recommendation of the Reference Committee.

BYLAWS

Chapter VIII—Procedure of Election Section 1—Nominating Committee

Current

(a) Each component society shall elect, at any meeting prior to March 31 of the fiscal year, one (1) of its elected delegates to serve as a member of the Nominating Committee at the next annual meeting of this Society. At the same time, each component society shall elect one (1) of its elected delegates to serve as the alternate member of the Nominating Committee.

Proposed

(a) Each component society shall elect, at any meeting prior to December 1 of the fiscal year, one (1) of its elected delegates to serve as a member of the Nominating Committee at the next annual meeting of this Society. At the same time, each component society shall elect one (1) of its elected delegates to serve as the alternate member of the Nominating Committee.

Adopted

This proposal would require the component societies to elect nominating delegates and alternates and so to notify the Medical Society of New Jersey by December 1 of a given fiscal year. Since the Nominating Committee now meets well in advance of the Annual Meeting and must publish its report, this change is necessary to enable the Medical Society of New Jersey to process required materials to nominating delegates and alternates.

The Committee on Revision of Constitution and Bylaws recommends adoption of this proposal.

Approved

The proposal was adopted in accordance with the recommendation of the Reference Committee.

BYLAWS

Chapter XI—Component Societies Section 2—Qualifications of Members

Current

(a) Component societies shall have the responsibility to judge the qualifications of an appli-

Proposed

(a) Component societies shall have the responsibility to judge the qualifications of an appli-

cant for any type of membership and alone shall have the power to elect him, but election thereto shall be contingent upon clearance of each eligible applicant's formal credentials as satisfactory by the Committee on Credentials of this Society.

cant for any type of membership and alone shall have the power to elect him, but election thereto shall be contingent upon clearance of each eligible applicant's formal credentials as satisfactory by the Committee on Credentials of this Society. *Prospective members whose formal credentials have been approved as satisfactory by the Committee on Credentials of this Society shall satisfactorily serve a six-months' probationary period before their election to membership.*

Not Adopted

This amendment provides for a probationary period for new members following the clearing of their credentials. The Committee on Revision of Constitution and Bylaws believes such a system is unwieldy and unnecessary. We, therefore, **recommend** that this proposal not be adopted.

Approved

The proposal was not adopted in accordance with the recommendation of the Reference Committee.

BYLAWS
Chapter XI — Component Societies
Section 4 — Associate Members

Current

(a) Associate members shall be those physicians admitted to component societies who otherwise comply with Section 2 of this Chapter but are not licensed to practice medicine and surgery in New Jersey but are serving in approved internship or residency programs.

Proposed

(a) Associate members shall be those physicians admitted to component societies who otherwise comply with Section 2 of this Chapter but are not licensed to practice medicine and surgery in New Jersey but are serving in approved internship or residency programs, *or are members of the Medical Society of New Jersey Student Association.*

Adopted

The Committee finds this concept, which would allow members of the Medical Society of New Jersey Student Association to become associate members of the State and Component Societies, a desirable method to promote an active recruitment program for the Medical Society of New Jersey and at the same time afford the opportunity to solidify the medical profession in New Jersey.

The Committee on Constitution and Bylaws **recommends** adoption of this proposal.

Approved

The proposal was adopted in accordance with the recommendation of the Reference Committee.

BYLAWS
Chapter VIII — Procedure of Election
Section 2 — Procedure of Nomination

Current

(a) The chairman of the Nominating Committee shall

Proposed

(a) Same

be the Immediate Past-President of this Society, or, in the event he is unable or unwilling to serve, a member designated by the Fellows. The Committee shall elect one (1) of its own members to serve as Secretary, who shall call the roll of accredited members of the committee as certified by the Secretary of this Society.

The chairman shall read to the committee this section of the Bylaws (Chapter VIII, Section 2) before proceeding to any other business.

(b) The Secretary of this Society shall furnish to the committee such information as is necessary for the proper conduct of its business, including a list of all offices to be filled.

(b) Same

(c) The Nominating Committee meeting shall be conducted in accordance with *Sturgis Standard Code of Parliamentary Procedure*. No candidate shall be considered by the Nominating Committee unless a curriculum vitae in conformity with the form utilized by MSNJ for those seeking elective office is available to the Nominating Committee.

(c) Same

(d) A majority vote of the members present shall nominate.

(d) Nominating Delegates and their Alternates shall not be considered by the Nominating Committee as candidates for any elective office.

Not Adopted

(e) A majority vote of the members present shall nominate.

The current Bylaws provide that the nominating procedure is to be governed by *Sturgis Standard Code of Parliamentary Procedure* which contains an admonishment against members of the Nominating Committee being considered as candidates for nomination by the Nominating Committee. At its February 1978 meeting, the Nominating Committee voted to ignore *Sturgis* and placed six of its members on the ballot for seven positions. Research reveals that virtually every association utilizing a nominating committee precludes the members of the Committee from appearing on the nominating committee report. The Committee on Constitution and Bylaws believes such a safeguard is essential to the function of a fair and objective nomination procedure if the Society is to continue to utilize a nominating committee mechanism.

This Committee therefore **recommends** that the above proposal prepared by the Committee on Constitution and Bylaws be adopted.

Not Approved

The proposal was not adopted. A Reference Committee suggested amendment to (d) also was rejected.

Supplemental Report

BYLAWS
Chapter I — Membership
Section 2 — List of Members

Current	Proposed
(a) The term member or membership unless otherwise qualified shall refer to those members having full privileges, including the right to vote and hold office.	(a) Same
(b) Five (5) days before the first of March the treasurer of each component society shall forward to the Treasurer of this Society a complete list, with names and addresses, of all paid up and exempt members in good standing in this Society, at the same time remitting the assessment covering such membership.	(b) Five (5) days before the first of <i>January</i> the treasurer of each component society shall forward to the Treasurer of this Society a complete list, with names and addresses, of all paid up and exempt members in good standing in this Society, at the same time remitting the assessment covering such membership.
Not later than the first day of March in each year, the secretary of each component society shall send to the Secretary of this Society a current list of associate, emeritus, and honorary members; members elected, deceased, and those who have resigned or moved from the county since the last report was submitted. Where members have transferred or have been received on transfer, the name of the county or state society to or from which they have transferred must be given.	Not later than the first day of <i>February</i> in each year, the secretary of each component society shall send to the Secretary of this Society a current list of associate, emeritus, and honorary members; members elected, deceased, and those who have resigned or moved from the county since the last report was submitted. Where members have transferred or have been received on transfer, the name of the county or state society to or from which they have transferred must be given.

Immediately after December 31 of each year, the Secretary of this Society shall notify each component society of the number of delegates to which it is entitled during the next succeeding year in the House of Delegates, based on the number of active members recorded in the office of the Secretary on that date. Associate membership shall not be included in such computation.

Not later than the first day of April in each year, the secretary of each component society shall send to the Secretary of this Society a complete list of the delegates and alternate delegates to this Society, together with the names of the delegate and alternate delegate to the Nominating Committee.

Not later than the first day of *March* in each year, the secretary of each component society shall send to the Secretary of this Society a complete list of the delegates and alternate delegates to this Society, together with the names of the delegate and alternate delegate to the Nominating Committee.

This proposal was forwarded to the Committee by the Board of Trustees via the Committee on Finance and Budget. Its purposes are to improve cash flow, improve record keeping, and enhance the efficient management of Society business. Your Committee finds these changes and goals to be desirable.

The Committee on Revision of Constitution and Bylaws **recommends** adoption of this proposal.

The proposed amendment was referred to the Board of Trustees for further study.

REFERENCE COMMITTEE "A"

Christopher Babigian, M.D., Bergen
Chairman
Salvatore J. Angelo, M.D., Ocean
Donald A. McLean, M.D., Salem
William A. Dwyer, Jr., M.D., Passaic
Fred M. Palace, M.D., Morris
Milton R. Bronstein, M.D., Middlesex
Alternate Member

Reports:
President
Board of Trustees
Secretary
Judicial Council
Executive Director
Committee on Credentials
Committee on Long Range
Planning and Development
Resolutions #1, #2, #3

President

Frank R. Begen, M.D., Teaneck

(Reference Committee "A")

This past year has been both rewarding and exciting. There were, of course, some fatiguing aspects of the job; but that was more than balanced by the opportunities to meet and work with many marvelous members of our Society plus other state and national societies.

Because of time demands, I was required to seek much assistance from staff. To a person, I never found them short of wonderful. In that respect, I also must acknowledge the superb efforts of our office secretary-receptionist, Mrs. Jackie Blauvelt. Without her there were times I would have been in Salem rather than Newark.

In my years coming through "the chairs," some people remarked that I was rather quiet. Well, I am a history buff and especially interested in President Lincoln and the Civil War. Therefore, I have never forgotten Lincoln's advice: "better to keep your mouth shut and be thought a fool than to open it and erase all doubt."

The main duties of the President are to represent the Society in ceremonial functions and to act as official spokesman. The number of days involved in these tasks are prodigious. Without the help of staff and the members of the Executive Committee, it would have been impossible to cover all the activities. There were many conflicting meetings, but we were well covered by our friends noted above.

The Society has chosen, most of the time, to elect a physician in the *active* practice of medicine to the post of Second Vice-President expecting that he will eventually be their President. If this philosophy is to continue, then the Society should make it financially possible for the President to make it a full-time job for his year in office. The pressure to deal with legislation, third parties, professional liability, environmentalists and other special interests, peer review, HSAs, IPA-HMOs, and others is enormous, not to mention the ceremonial aspects of the position. What happens is that both the doctor's practice and the Society suffer because he is unable to do a complete job for either area. In addition, it will take him considerable time to rebuild his practice. I have been fortunate this year to be serving at a time when two outstanding men, James S. Todd, M.D., Chairman of the Board, and Vincent A. Maressa, J.D., Executive Director of the Society, have been helping field most problems. But, the

day is fast approaching when the President must put full time into Society business.

In addition to attending all of the Board of Trustees' meetings and all of the Executive Committee meetings, your President has attended many other functions. The highlights of these functions will be listed with remarks where they are deemed appropriate.

First, we will list the counties visited (in alphabetical order) for either business or ceremonial representation:

Atlantic	Mercer
Bergen	Morris
Burlington	Passaic
Essex	Salem
Hudson	Union

The reception your President received in all of these counties was cordial and the lessons learned rewarding. Advice to incoming Presidents—always be prepared to talk *briefly* on some current problem or accomplishments of interest to the Society, and don't miss the "Plank Shad" dinner in Salem!

In addition to those states visited on AMA or MSNJ business, two other states were visited by invitation of their state society—Pennsylvania, to their annual convention, and Delaware twice, their annual convention and the meeting of the Mid-Atlantic States' liaison committees. This latter consists of representatives of the Medical Societies of Virginia, Maryland, Washington D.C., Delaware, Pennsylvania, and New Jersey, and the purpose is to discuss mutual problems with suggestions for solutions. In addition several parochial problems are discussed with local solutions presented. Maryland also has invited your President to its annual convention, but this occurs several days after Doctor Krueger will be installed and thus it becomes his pleasure to attend. Again, we must remark that the hospitality extended to Mari and I was most gracious and rewarding. Advice to future Presidents—don't miss any of these functions!

The President attended four significant AMA meetings. Or, perhaps I should say three and one-half—we flew over one. They were: the Annual AMA Convention in San Francisco in June 1977; the Clinical Session in Chicago in December 1977; the AMA-sponsored State Health Legisla-

tion Symposium in Tampa, Florida in January 1978; and, an attempt at the Leadership Conference in Chicago in January 1978. Reports of these meetings were submitted to the Board of Trustees either orally or in writing. As a result of the report of our unsuccessful attempt to attend the Leadership Conference, your Board voted to request the AMA to change the location or time of this meeting.

All of the councils of MSNJ were attended at least once, and in addition many of the subcommittee meetings. These included: Emergency Medical Care, Medicaid, Impaired Physicians, Medical Defense and Insurance, Medical Education, Medical Services, Legislation, Child Health, and the Committee on Annual Meeting.

The President of MSNJ automatically is appointed to the Board of Trustees of New Jersey Blue Shield, and in that role I attended the majority of their meetings. This I found to be an important function, helpful to both organizations.

A meeting was held with the President and Executive Secretary of the Academy of Medicine of New Jersey to discuss the formation of a Speaker's Bureau in mutual cooperation with MSNJ. Leon Smith, M.D., subsequently submitted a list of 29 topics that would be of interest to physicians and the public at large. To date this has not been followed up, but I feel it has merit and should be pursued.

Approximately every two months meetings were held between the Executive Committees of the New Jersey Hospital Association and MSNJ to discuss mutual problems and divergent points of view. Needless to say, in the present atmosphere of public and government animosity toward the "health care delivery system," this is one of our most important liaisons. As our courtship has progressed, our mutual respect has increased. This is becoming an important bulwark for both organizations and should be nurtured.

Our relations with the Department of Health have shown improvement. There have been no vitriolic confrontations and we are working together from more enlightened points of view. This is especially true in our mutual efforts to evaluate and validate the use of DRGs (diagnostic-related groups).

Another most important liaison we maintain is with the Judiciary and the Bar. In June 1977, your President attended the inaugural dinner of the President of the New Jersey Bar

Association in Atlantic City. Shortly after this writing we will meet with the liaison committee of the Bar Association to discuss the adoption of an interprofessional code.

Three meetings were held with the Supreme Court Committee on Relations with the Medical Profession. As a result, a program was worked out to create, define, and implement a mandatory screening program for all professional liability suits. This plan, known as Rule 4:21, will be presented to the New Jersey Supreme Court for their approval. If this is obtained, Rule 4:21 will become a mandatory screening mechanism.

Other important organizations we had dealings with are:

1. National Committee To Declare War on Drugs
2. CMDNJ graduation exercise
3. Board of Medical Examiners of New Jersey
4. Interprofessional Council (Dental, Osteopathic, Podiatry, Pharmaceutical, Optometric, Psychological)
5. Liaison Organizations (New Jersey Dental Association, New Jersey Hospital Association, New Jersey State Bar Association, New Jersey State Nurses' Association, New Jersey Association of Osteopathic Physicians and Surgeons, New Jersey Pharmaceutical Association)

In addition to participation in the above mentioned activities, I consider as significant contributions:

1. The referral, with Board approval, of the request to the Council on Medical Services to make a study of the medical care delivery system in New Jersey, and to identify areas of poor distribution and make recommendations on how to improve this problem.
2. The creation of the Ad Hoc Committee to Study the AMA-Sponsored Report on the Cost of Medical Care. This Committee will report to the Board in April and our delegates to the AMA will have ample time to study and discuss this problem before the AMA Annual Meeting in June.

Members and staff, I am proud to have served with you. Thank you for your support, patience, and trust.

As the year draws to a close, you get the feeling that it ends just when you are learning the game. I will be available in the future to help MSNJ in any endeavor in which you feel I have worth.

Filed in accordance with the recommendation of the Reference Committee.

Board of Trustees

James S. Todd, M.D., Chairman, Ridgewood

(Reference Committee "A")

Once again, it is my privilege and duty to report the salient activities of the Board of Trustees for the past year. Old problems as well as new have challenged the Board. Most noticeable among those old problems remains that of apathy at all levels of the Society. Once again we are in danger of losing another AMA delegate because not enough of us believe in going all the way with organized medicine. Attendance at Board meetings by county presidents and specialty society presidents remains amazingly low compared to the reactive cries when a Board decision, in which they might have participated, is not to their liking.

On balance, however, the Medical Society is making inroads in areas never before attempted. When threatened with a suit, the State Medicaid Administration backed down on using the Social Security number as a physician identifier. The Commissioner of Health now actively is seeking our advice in regard to rate making, certificate of need, and other areas of vital concern to the privately practicing physician. Specialty societies now are coordinating their activities with those of the Society. The State Board of Medical Examiners sought our counsel on the guidelines for advertising, and accepted our suggestions. In all areas, the voice of the Medical Society is growing stronger, and, with broader cooperation at the county and specialty level, should grow even stronger.

Vexing problems of uncertain solutions remain, and will require the ultimate in wisdom, fortitude, and cooperation if they are to be conquered. Cost containment, while lacking a visible public constituency is a prime priority for the government, and the health care system runs the risk of an all-too-quick, "me-too" response, losing sight of the fact that high-quality care in an inflationary society is bound to be expensive, and with the increasing number of patients treated, it will continue to be so. MSNJ and the New Jersey Hospital Association have formed a joint committee to look rationally at cost containment in New Jersey. This endeavor should bring knowledge to the public and credit to the profession.

Next, is the problem of health planning, and the irrational political system of the HSA run by radical professional planners and supported by hostile uninformed consumers. Without question, planning is essential, but it is not an activity compatible with political pressures. Rational, factual decisions can and should be made regarding resources and utilization, but only in a calm atmosphere of cooperation and mutual respect. Given the current system in New Jersey, physicians at all levels must become ever more vocal and knowledgeable in the workings of HSA, so that planning will become more rational and less political. While this is primarily a local responsibility, the Society is attempting to develop guidelines to contain the current irrational system.

Finally, of great concern to the Society is the future of medical practice. From all sides come conscriptions, limitations, and new alternatives until some fear for their very professional lives as private practitioners. In cooperation with the Foundation for Health Care Evaluation, information concerning Independent Practice Associations is being developed with the hope this will be a viable alternative to closed-panel, pre-paid programs. Development in this area is slow, but optimism still exists.

Conspicuous by its absence is the issue of professional liability insurance. Our Society-owned company has managed to hold rates steady (and in effect by doing so, is forcing the Insurance Commissioner to do likewise) and is now addressing the problems of more effective claims' management and the prevention of malpractice. Make no mistake about it, the basis of our current problem is indeed negligence, and all the legal reforms and claim efficiency will not eradicate that fact. Attention increasingly will be directed toward risk management, and while many will find it burdensome, ultimately negligence will diminish.

Perhaps, the byword for this past year should be cooperation, as we have seen increasing cooperation among the constituency and those with whom we have to deal. The byword for this coming year should be action—action based upon knowledge and cooperation. To this end the Board pledges its efforts.

Filed in accordance with the recommendation of the Reference Committee.

Other activities that occupied the Board are as follows:

ABORTIONS

(Reference Committee "A")

New Jersey introduced a resolution at the AMA Interim Meeting requesting that the AMA advise the appropriate organizations and agencies that elective abortion services rendered under Medicaid and in other third party payment programs should be recognized as compensable services.

The resolution was adopted and referred to the AMA Board of Trustees.

Filed in accordance with the recommendation of the Reference Committee.

AMA DELEGATION

(Reference Committee "A")

Once again this year, the Board instituted a vigorous campaign for Society members to join the AMA. This was occasioned by the AMA membership figures which indicated that MSNJ needed an additional 43 AMA members to maintain its current delegation strength of 7, or an additional 1,043 to return to an eight-member delegation.

Filed in accordance with the recommendation of the Reference Committee.

ASSOCIATE—INTERN AND/OR RESIDENT—MEMBERS

(Reference Committee "A")

The following ruling of the Committee on Credentials governing advancement of interns and/or residents from associate to regular membership was approved:

"Upon receiving licensure to practice medicine and surgery in New Jersey a physician previously elected to associate membership (intern and/or resident) must submit a new application to the State Society Committee on Credentials for approval before elevation to regular, active membership."

Filed in accordance with the recommendation of the Reference Committee.

HEALTH CARE ADMINISTRATION BOARD REGULATION

(Reference Committee "A")

The Executive Committee, in consultation with the Radiological Society of New Jersey and the New Jersey Hospital Association, was empowered to develop a position paper in response to the following regulation adopted by the Health Care Administration Board:

"In addition, an application facility must document all remuneration and charges for its professional component. Professionals shall be required to have a contract with a facility and all professional contracts must be filed with the documentation."

Filed in accordance with the recommendation of the Reference Committee.

COUNTY AND SPECIALTY SOCIETY RELATIONS

(Reference Committee "A")

MSNJ's staff was authorized to implement a suggestion from the Chairman that communication be made with the county and specialty societies urging them to request the assignment of a Trustee to attend one of their meetings for the purpose of promoting greater understanding and rapport between these organizations and the physicians they represent.

Filed in accordance with the recommendation of the Reference Committee.

MEDICAL SOCIETY OF NEW JERSEY STUDENT ASSOCIATION

(Reference Committee "A")

During the summer, the Board authorized the formation of a student group known as the Medical Society of New Jersey Student Association.

Representatives of MSNJSA attend monthly meetings of the Board and present reports for consideration.

Student members have been placed on the Society's overall membership mailing list and receive *The Journal* and the *Membership Newsletter*.

Financial assistance also has been granted for two students (one from each school) to attend the American Medical Student Association Annual Meeting in Atlanta, Georgia.

The Board urges component societies to sponsor a student, who is a resident within the county, to attend the Annual Meeting of the Medical Society of New Jersey.

Filed in accordance with the recommendation of the Reference Committee.

NEGOTIATING TEAM

(Reference Committee "A")

As a result of a communication from the Union County Medical Society commending the staff of MSNJ on the excellence of the seminar on "The Art of Negotiating" and suggesting that the Board give serious consideration to the formation of a negotiating team, the staff is compiling a list of potential candidates, suggested by component societies, willing to serve as a potential negotiating team.

Filed in accordance with the recommendation of the Reference Committee.

NUCLEAR MEDICINE TECHNOLOGY

(Reference Committee "A")

Received as informative by the Board was MSNJ's letter to the Bureau of Radiation Protection, Department of Environmental Protection, expressing concern about the creation of a field of licensure with legislative authorization via adoption of regulations which exceed the existing statutory grant of authority.

On July 13, 1977, Thomas Witomski, M.D., representing MSNJ and the New Jersey Radiological Society, presented testimony at a hearing opposing proposed regulation on nuclear medicine technology.

Filed in accordance with the recommendation of the Reference Committee.

SPRING AND FALL CONFERENCES

(Reference Committee "A")

In October, the Board hosted an all-day session for 66 presidents and presidents-elect of component and specialty societies and executives of component societies.

The program featured panelists who discussed professional liability and legislation. There was also a general session with the Board of Trustees.

Another all-day session will be held in April. As an innovation, invitations also have been extended to chiefs of staff of all New Jersey hospitals.

The program for this session will feature such topics as certificate of need and cost containment in New Jersey, and regulation, licensure, and medical discipline.

Filed in accordance with the recommendation of the Reference Committee.

TEMPORARY LICENSURE OF PHYSICIANS

(Reference Committee "A")

The New Jersey State Board of Medical Examiners, at its June 8 meeting, reaffirmed its previous position of opposition to temporary licensure of physicians to practice medicine and surgery in the State of New Jersey.

Filed in accordance with the recommendation of the Reference Committee.

UNLICENSED PHYSICIANS PRACTICING IN STATE HOSPITALS

(Reference Committee "A")

In September, the Board voted to support the position of the State Board of Medical Examiners and the New Jersey Hospital Association that called for the termination of the statute allowing unlicensed physicians to practice in State hospitals.

Filed in accordance with the recommendation of the Reference Committee.

1978 NOMINATING COMMITTEE REPORT

(Reference Committee "A")

The Speaker of the House of Delegates submitted a memorandum to the Board of Trustees calling attention to two defects in the 1978 Nominating Committee report which

had been prepared for distribution to the House of Delegates. The specific defects were as follows:

1. Ineligible Candidates—In 1972, the House of Delegates adopted a resolution which declared that “no member shall serve more than three successive two-year terms as an AMA Delegate.” In 1973, the House of Delegates adopted a Bylaw which stated that no member “shall serve more than three two-year terms as an AMA Delegate.” Likewise, no member shall serve more than three two-year terms as an Alternate Delegate.

Both Doctor Frank J. Hughes and Doctor Emanuel M. Satulsky began two-year terms in January of 1973 and have continued to serve successive two-year terms which began in January of 1975 and January of 1977. They are, therefore, not eligible to begin serving a term which would begin in January 1979.

The Nominating Committee chose to consider the Bylaw (adopted in 1973) as all controlling and mutually exclusive vis a vis the 1972 resolution. Proper interpretation is that the Bylaw was complementary and expanded the scope of the resolution and in no way terminated its operative effect.

Based upon the foregoing, and the concurring opinion of Legal Counsel, the Board determined that Doctors Hughes and Satulsky were ineligible for re-election to the position of

AMA Delegate. The Board voted to call a special meeting of the Nominating Committee (March 28, 1978) for reconsideration of the positions left vacant. The amended Nominating Committee report is before the House.

2. Procedure—The Medical Society of New Jersey Bylaws require the Nominating Committee to meet in conformity with *Sturgis Standard Code of Parliamentary Procedure*. That Code provides that should Nominating Delegates become candidates for elective office, they should “resign from the Committee immediately.”

At least six of the candidates on the Nominating Committee ballot served on the Nominating Committee. The minutes reveal that the Committee voted to ignore *Sturgis* in this regard. No Committee has the authority to suspend the Bylaws and their requirements.

Pursuant to the Bylaws and acting as the supreme authority of the Society between annual meetings, the Board voted retroactively to suspend the procedural rules calling for the resignation of Nominating Delegates who have become candidates.

Filed in accordance with the recommendation of the Reference Committee.

Secretary

Arthur Bernstein, M.D., Chairman, Maplewood

(Reference Committee "A")

The office of the Secretary has continued its usual routines, primarily involving maintenance of membership records, correspondence, telephone inquiries, and completion of numerous questionnaires originating from various sources.

During the administrative year, the Secretary attended the meetings of the Board of Trustees and the several committees of which he is chairman, member, or advisor.

Membership (as of December 31, 1977)

Active:	Paid	8,017	
	Exempt	852	8,869***
*Associate:	Paid	16	
**Affiliate:	Paid	70	
	Exempt	2	
State Emeritus		515	
Total of Above		9,472	
State Honorary		8	
New and Reinstated Members:			
Active		557	
State Emeritus		1	
*Associate		13	
**Affiliate		3	
Transfers within the state		45	
Transfers out of state and resignations		185	
Members deceased		137	
Members dropped:			
Active (non-payment of dues)		176	
(N.J. licensure revoked)		1	
(N.J. licensure suspended)		2	
(N.J. licensure voluntarily surrendered)		5	
*Associate (non-payment of dues)		85	
**Affiliate (non-payment of dues)		2	271

*Associate membership (non-licensed in N.J.) designates Interns and Residents.

**Affiliate membership—physicians who no longer practice in New Jersey.

***Adjusted for transfers out of state, resignations, and deaths.

AMA MEMBERSHIP

A total of 6,198 members of the Medical Society of New Jersey maintain active membership in the AMA. The Society's representation in the AMA House of Delegates is seven delegates—one for each thousand members, or fraction thereof.

MEMBERSHIP DIRECTORY

Work is being carried forward to achieve the publication of the next edition of the *Membership Directory* in the fall of 1978, when, it is expected, distribution will be made to the entire membership.

The new *Directory* will be printed in the current format, similar to the 1976-77 edition with the following two restrictions: (1) restrict each member to a maximum of two (2) office listings, primary and secondary; (2) restrict each member's listing to include only board certifications, fellowships, county society and AMA membership. The hospital appointments and medical affiliations will be listed as usual.

Otherwise, the new *Directory* will embody the same features as that of the 1976-77 edition. These include: (1) the presentation in bold print of the "type of practice" in the individual listing directly following the name, and preceding the address; (2) a single asterisk (*) to designate "armed forces," a single dagger (†) to designate affiliate membership, a double dagger (††) to designate emeritus membership, and a triple dagger (†††) to designate associate membership; (3) the zip code will appear as the last item in each individual listing; (4) the hospital section of the *Directory* again will include the listings of hospital staffs; and (5) the special membership supplement section, which includes the Constitution and Bylaws of MSNJ, the AMA Principles of Medical Ethics, the Basic Concepts Underlying the Provision of Professional Medical Care, Legal Obligations Affecting Medical Practitioners in New Jersey, Guides for Physician-Hospital Relationships in New Jersey, and a list of Poison Control Centers in New Jersey.

Verification data sheets supplied to the membership will form the basis for the biographical data to be published in the 1978-79 edition, as did similar data sheets which were supplied to publish the 1976-77 *Membership Directory*. However, this year, to conserve the time of our members in verifying biographical data, we have tested and introduced a telephone verification program. By using toll-free numbers to allow personal contact, we have had a greater response than by the mail program alone. With the continued cooperation of the membership, your Committee hopes to make this forthcoming *Directory* the most complete and accurate edition yet published.

Filed in accordance with the recommendation of the Reference Committee.

Judicial Council

Albert F. Moriconi, M.D., Chairman, Trenton

(Reference Committee "A")

Apart from its work as an appellate tribunal considering matters originally dealt with by county judicial committees, the Judicial Council has responsibility, under the Bylaws, to supervise, direct, and keep records of all complaints dealt with by county judicial committees as matters of original

jurisdiction. To accomplish this function, the Council—with the cooperation of county judicial committees—receives reports of all complaints accepted by county judicial committees and the dispositions made of them.

From the official findings, the Council here presents a

summary of its operations and those of county judicial committees for the period from June 29, 1977 to March 5, 1978.

By Judicial Committees

Complaints reported as disposed of	62
Alleging:	
Dissatisfaction concerning fees	49
Dissatisfaction concerning medical procedures	5
Unprofessional conduct	5
Dissatisfaction concerning professional ethics	4

By Judicial Council

Meetings held	5
Official communications acted upon	50
Appeal hearings requested	6
Appeal hearings granted	1
Formal opinions rendered	0

Analysis of the types of complaints presented against our member-physicians indicates a substantial increase in the number of those alleging "dissatisfaction concerning fees." We again stress the fact that, wherever possible, it is wise and desirable that a clear understanding be arrived at between physician and patient regarding this matter, before treatment is undertaken.

The Council takes this opportunity to emphasize that

decisions of judicial committees of component societies are binding upon all members. The judicial committee of each component society, in the enforcement of its findings duly arrived at, has the power to censure, suspend, or expel any member of its society for just cause.

There generally has been a favorable reaction to MSNJ's efforts to assure the public that we do not condone professional misconduct and are not in sympathy with those members who ignore their responsibilities. While judicial committees act primarily in the public interest, they also serve to keep the physician's record clear among his colleagues when he has been accused unjustly.

Judicial Workshop

At this writing plans are being made to conduct a Judicial Workshop for chairmen, chairmen-elect, secretaries, executive secretaries, and any members of the judicial committees of component societies who may wish to attend. Procedural issues, the judicial mechanism itself, and any deficiencies in our *Rules and Regulations* are a few of the topics that will be under discussion.

Filed in accordance with the recommendation of the Reference Committee.

Executive Director

Vincent A. Maressa, Trenton

(Reference Committee "A")

Rarely do new issues arise in the socio-economics of health care and medical practice. Most of the problems have existed for decades. The phenomenon is such that in a given year or span of years a certain issue rises from the sea as the iceberg rolls and we face what appear to be new items of dramatic concern. Actually, what we really are observing is nothing more than an acute episode in the management of a chronic disease.

This year the HSA - Cost Containment scenario dominated Society activity, with the Certificate of Need, Medicaid, and professional liability insurance continuing as major concerns.

Unfortunately, again I must bring to your attention my belief that until this Society develops a rational policy toward ancillary personnel and the other health care disciplines which practice via an independent but limited license, we will continue to face frustration and defeat in our dealings with the public, the legislature, and the executive branch of government. I plead for reason, logic, and consistency in that policy.

On February 28, 1978, the Medical Society of New Jersey purchased a new headquarters facility located on an 8.5 acre tract on the Princeton Pike in Lawrenceville, New Jersey. The building contains 47,000 square feet of space with the potential for addition within the existing structure of another 15,000 square feet. Remodeling and design is being conducted under the auspices of Harold Davidson, Architect, and George Koch, Design Specialist. It is anticipated that the Medical Society of New Jersey will move into the new location in the early Fall of 1978.

The facility will provide the Society, the Academy of Medicine, the New Jersey Foundation for Health Care Evaluation, and the New Jersey Medical Underwriters, Incorporated, with ample office and meeting space along with on-site parking for more than 300 automobiles with the potential for expansion to accommodate any future needs that may arise.

Filed in accordance with the recommendation of the Reference Committee.

Credentials

Arthur Bernstein, M.D., Chairman, Maplewood

(Reference Committee "A")

Throughout the year the Committee on Credentials reviewed and acted upon membership applications and their supporting credentials as submitted through the component societies.

The following statistical breakdown reflects the Committee's activities during the period March 1, 1977 to February 28, 1978.

	<i>*Associate</i>	<i>Active</i>	<i>Osteo- paths</i>	<i>Grand Total</i>
<i>Received:</i>				
*Interns	0			
*Residents	0			
Grand Total	0	510	7	517
<i>Reviewed and found</i>				
(A) Satisfactory				
*Interns	0			
*Residents	0			
Sub-Total	0	490	5	495
(B) Unsatisfactory	0	0	0	0

Pending:				
*Interns	0			
*Residents	0	20	2	22
Grand Total	0	510	7	517

*Associate membership (non-licensed in New Jersey) designates Interns and Residents.

The Committee extends appreciation to the secretaries of component societies, and to those who assist them, for their cooperation in processing membership applications. It would be especially helpful to the Credentials Committee of MSNJ if those who process credentials in the component societies would call specific attention to any deficiencies or questionable data being submitted on the application forms. This procedure will help insure a more accurate and speedy evaluation of credentials.

Filed in accordance with the recommendation of the Reference Committee.

Long Range Planning and Development

William J. D'Elia, M.D., Chairman, Spring Lake

(Reference Committee "A")

The Committee has had no formal meeting this year and thus has no formal report to make to the House.

The Reference Committee noted that the Committee had not met and felt that was a deficiency which should not be allowed to recur.

Filed in accordance with the recommendation of the Reference Committee.

Resolutions

#1 Mandatory AMA Membership

From the Bergen County Medical Society

(Reference Committee "A")

Whereas, the impact of pressure from various public and private bodies is increasingly encroaching upon the private practice of medicine; and

Whereas, the need for a unified organization on the part of all physicians is essential; and

Whereas, the American Medical Association is the logical organization that cuts across all local and specialty societies to speak for organized medicine; and

Whereas, the American Medical Association increases its political "clout" in direct proportion to its number of members and financial ability; and

Whereas, the Medical Society of New Jersey increases its political impact in proportion to its participation in the American Medical Association; now therefore be it

RESOLVED, that the Medical Society of New Jersey adopt a unified membership policy and that membership in the American Medical Association be mandatory for all Medical Society of New Jersey members.

Rejected as written

Reference Committee recommended rejection of Resolution #1 as written and the adoption of the following Substitute Resolution #1:

RESOLVED that the Medical Society of New Jersey adopt a membership policy that [encourages voluntary] membership in the American Medical Association.

Amended from the floor of the House by substituting the word "requires" for the words "encourages voluntary" to read:

RESOLVED that the Medical Society of New Jersey adopt a membership policy that requires membership in the American Medical Association.

Adopted as amended by the House.

#2 Support Concept of Hospices

From Gertrude Oberlander Ash, M.D., Delegate, Essex County

(Reference Committee "A")

Whereas, the inspirational concept of "hospice" has been published in *The Washington Post* and the *Congressional Record* in January, 1978; and

Whereas, general hospitals are costly and not geared to cope properly with the problems of the terminally ill in a manner that the patient and the patient's family deserve; and

Whereas, many terminal patients do not require acute care, but need palliative therapy, relief of pain and anxiety, and the creation of an atmosphere which will permit them to die in dignity; and

Whereas, the hospice concept is a specialized approach to terminally ill patients and their families in a loving, supportive, human environment in a home care program and/or in a hospice facility; now therefore be it

RESOLVED, that the Medical Society of New Jersey support the concept of hospice so that people who are terminally ill may die in surroundings more homelike and congenial than the usual hospital environment; and be it further

RESOLVED, that the Medical Society of New Jersey contact all media in the State to indicate that physicians consider this specialized approach to terminal care to be of great value; and be it further

RESOLVED, that a resolution of support for this concept be drafted and sent to the AMA and have the support of our New Jersey Delegation to their national House of Delegates.

Adopted in accordance with the recommendation of the Reference Committee.

#3

Use of Amphetamines

From the Burlington County Medical Society

(Reference Committee "A")

Whereas, the State Board of Medical Examiners has issued directives concerning the use of amphetamines and certain sympathomimetic amines; and

Whereas, the proposed standards of use for these drugs were apparently drawn up without consultation with knowledgeable physicians who are cognizant of the clinical applications of these drugs; and

Whereas, the standards which *were* drawn up were not disseminated to all practicing physicians in the State before the regulations were enforced; and

Whereas, the standards were applied retroactively; and

Whereas, unacceptable tactics were used during the investigation of physicians suspected of violating the standards; and

Whereas, the mechanism of Judicial Notice was applied; and

Whereas, accused physicians were not allowed the privilege of evaluation by their peers; now therefore be it

RESOLVED, that clinical use of amphetamines and certain related sympathomimetic amines include: narcolepsy, minimal brain dysfunction, depression, seizure disorders in conjunction with other appropriate medications, hypersomnia, and that the use of amphetamines and certain related sympathomimetic amines be considered not usually an acceptable modality of treatment of obesity; and be it further

RESOLVED, that the Medical Society of New Jersey request the State Board of Medical Examiners to adopt the following procedures:

(a) That in the future all prescribing standards be drawn up only after consultation with physicians who have working knowledge of the drugs in question;

(b) That once adopted, the standards must be disseminated *promptly* to all practicing physicians in the State;

(c) That the standards *never* be applied retroactively;

(d) That physicians suspected of wrongdoing must be evaluated by appropriate peer review committees and consultation must be obtained from these committees by concerned State agencies before a determination of guilt is made;

(e) That punishments to be meted out must be made commensurate with the severity of the violation;

(f) That in appropriate instances, rehabilitation, rather than punishment, should be the goal for which we strive; and be it further

RESOLVED, that the Medical Society of New Jersey, through its Board of Trustees, transmit the foregoing proposals to the State Board of Medical Examiners and seek the adoption of the guidelines by the State Board of Medical Examiners.

Adopted in accordance with the recommendation of the Reference Committee.

REFERENCE COMMITTEE "B"

William J. Kustrup, M.D., Mercer

Chairman

Glenn P. Lambert, M.D., Hunterdon

Edward A. Schauer, M.D., Monmouth

Michael J. Larkin, M.D., Mercer

B. Ralph Wayman, M.D., Mercer

John R. Doyle, M.D., Bergen

Alternate Member

Reports:

Board of Trustees' Item

Treasurer

**Committee on Finance
and Budget**

Committee on Medical Student

Loan Fund

Committee on Publication

Board of Trustees' Item

IPA/HMO CONSORTIUM (Reference Committee "B")

The Executive Committee, and subsequently the Board of Trustees, heard a presentation from the New Jersey Foundation for Health Care Evaluation, requesting funding for the development of an IPA/HMO Consortium consisting of all county medical societies, the New Jersey Society of Osteopathic Physicians and Surgeons, industry, and other interested parties whose purpose would be to provide support and information regarding the formation and management of IPAs/HMOs.

The following recommendations of the Executive Committee were approved, as amended, by the Board:

a. That the proposal be funded by the Medical Society of New Jersey in the amount of \$50,000 for its first year of operation.

b. That this money be obtained by an additional special assessment on the members of MSNJ. (It is anticipated that other participating groups in the Consortium will make similar proportionate contributions.)

c. That one of the objectives of this Consortium shall be to study the practicality and ability to develop a single state-wide IPA/HMO. This study is to be completed and ready for reporting to MSNJ's Board of Trustees within six months of receipt of MSNJ funding.

Filed in accordance with the recommendation of the Reference Committee.

Treasurer

Rudolph C. Gering, M.D., Treasurer

(Reference Committee "B")

This 1978 interim financial report of your Treasurer has been prepared from the books and records of the Medical Society of New Jersey.

The Balance Sheet is presented as of March 31, 1978 and May 31, 1977. Figures at March 31, 1978 have not been audited, for the reason that the fiscal year of the Society does not end until May 31, 1978. The figures at May 31, 1977 have been abstracted from the report of audit dated August 24, 1977.

The Statement of Revenue, Expenditures, and General Surplus Unappropriated presents the transactions of the Society for the ten months ended March 31, 1978 and the year ended May 31, 1977.

Revenues have been examined on a test basis and disbursements have been test checked to approved supporting vouchers by the Society's independent accountants. The cash

balances at March 31, 1978 were reconciled with the bank statements but were not confirmed directly with the depositories. Revenues from counties for dues assessments were checked in detail to reports on file, but were not confirmed with county treasurers at this time. Investments were not physically examined or confirmed at March 31, 1978.

These financial statements have been prepared in a form similar to the annual audit report, in order to show in greater detail the assets, liabilities, and fund balance, operating revenue and expenditures of the Society, in conformity with Resolution #28 approved by the 1968 House of Delegates under the heading "Annual Financial Report".

Filed in accordance with the recommendation of the Reference Committee.

Balance Sheet—General Fund

	March 31, 1978 (Unaudited)	May 31, 1977 (Audited)
Assets:		
Cash (Page Tr 27)	\$ 437,300.88	\$1,313,192.82
Investments at Cost (Page Tr 27)	990,564.95	392,081.25
Accounts Receivable—Members' Assessments	239,310.00	97,830.00
Accounts Receivable—Other	8,475.08	7,337.75
Note Receivable—N.J. State Medical Underwriters, Inc.	89,159.11	104,861.07
Notes Receivable—Physicians	23,400.00	23,400.00
Maternity Service Record Books— Inventory at Cost	1,503.88	2,485.42
Deferred Expense—Construction Loan	37,500.00	45,000.00
Deferred Expense—Telephone System	11,729.00	14,899.00
Deferred Expense—Membership Directory	10,013.97	19,349.97
Interest Income Receivable	17,555.96	19,828.18
	<u>\$1,866,512.83</u>	<u>\$2,040,265.46</u>
Land, Building and Equipment	\$ 381,259.26	\$ 374,090.90
New Executive Offices	1,028,700.00	—0—
	<u>\$1,409,959.26</u>	<u>\$ 374,090.90</u>
Accumulated Depreciation	(187,179.38)	(178,759.38)
	<u>\$1,222,779.88</u>	<u>\$ 195,331.52</u>
Total Assets	<u>\$3,089,292.71</u>	<u>\$2,235,596.98</u>

Balance Sheet—General Fund Liabilities and Fund Balances

	March 31, 1978 (Unaudited)	May 31, 1977 (Audited)
Liabilities:		
Unexpended Budget Appropriations (Page Tr 23)	\$ 155,884.36	\$ —0—
Notes Payable—Bank	11,729.00	14,899.00
Mortgage Payment—Bank	816,575.00	—0—
Accounts Payable	1,250.00	62,154.55
Deferred Income—Assessments Collected Applicable to Succeeding Year (Page Tr 24)	531,024.38	537,616.03
Due to Medical Student Loan Fund	45,971.58	45,215.81
AMA Collection Fees Payable	—0—	2,832.50
N.J. Sales Tax Payable	68.00	112.80
Payroll Taxes Payable	5,968.44	2,021.81
Funds for Specific Purposes:		
House Restoration and Replacement	4,173.79	4,173.79
Maternity Service Record Books	1,503.88	2,485.42
Litigation Fund Reserve	14,408.57	14,408.57
Professional Liability—Mandatory Assessment (Page Tr 27)	1,107,395.95	1,083,404.65
N.J. Foundation for Health Care Evaluation—Assessments (Page Tr 26)	58,400.00	7,480.00
Annual Meeting	6,929.84	—0—
General Fund Balances		
Unappropriated Fund Balance (Page Tr 27)	133,930.04	263,460.53
Land, Building and Equipment	194,079.88	195,331.52
Total Liabilities and Fund Balances	<u>\$3,089,292.71</u>	<u>\$2,235,596.98</u>

Statement of Revenue, Expenditures
and General Fund Balance (Unappropriated)

	Ten Months Ended March 31, 1978 (Unaudited)	Year Ended May 31, 1977 (Audited)
Revenue:		
Assessments Earned	\$ 916,919.15	\$897,912.50
Income on Savings Accounts and Certificates of Deposit	9,691.69	23,901.93
Income on Investments	14,158.34	13,819.88
Maternity Service Record Books Sales	981.54	511.76
<i>The Healing Art</i> Book Sales	— 0 —	20.00
Rental Income Net	<u>3,743.95</u>	<u>1,815.72</u>
Total Revenue	<u>\$ 945,494.67</u>	<u>\$937,981.79</u>
Expenditures:		
Budget Appropriation	\$1,022,904.00	\$873,705.56
Depreciation	<u>8,420.00</u>	<u>10,105.00</u>
Total Expenditures	<u>\$1,031,324.00</u>	<u>\$883,810.56</u>
Excess of Expenditures over Revenue or Excess of Revenue over Expenditures before Medical Journal, Annual Meeting, and Prior Year's Income and Expenses	<u>(\$ 85,829.33)</u>	<u>\$ 54,171.23</u>
Medical Journal, Annual Meeting, and Prior Year's Net Income and Expenses		
Medical Journal Deficit	(\$ 49,514.69)	(\$ 65,611.73)
Annual Meeting	— 0 —	(19,389.80)
Prior Year's Income and Expenses	<u>6,031.47</u>	<u>1,343.16</u>
	<u>(\$ 55,546.16)</u>	<u>(\$ 83,658.37)</u>
Net Increase or Decrease in Fund Balance (Unappropriated) from Operations	<u>(\$ 141,375.49)</u>	<u>(\$ 29,487.14)</u>
Fund Balance (Unappropriated) Transfers:		
Reclassification of Physicians' Relief Fund	\$ — 0 —	\$ 40,555.50
Reclassification of Litigation Fund Reserve	— 0 —	— 0 —
Included in 1975-76 Budget Appropriations	— 0 —	(4,787.55)
Depreciation Expense	8,420.00	10,105.00
Mortgage Payment — Budget Appropriations	<u>3,425.00</u>	<u>— 0 —</u>
	<u>\$ 11,845.00</u>	<u>\$ 45,872.95</u>
Net Increase or Decrease in Fund Balance (Unappropriated)	(\$ 129,530.49)	\$ 16,385.81
Balance, Beginning	<u>\$ 263,460.53</u>	<u>\$247,074.72</u>
Balance, Ending	<u><u>\$ 133,930.04</u></u>	<u><u>\$263,460.53</u></u>

Statement of Expenditures—General Fund
For the Ten Months Ended March 31, 1978
(Unaudited)

Account	Adopted Budget 1977-78	Total Expended	Balance Unexpended
Executive Salaries	\$ 145,327.00	\$124,508.37	\$ 20,818.63
General Staff Salaries	291,797.65	236,668.41	55,129.24
General Executive Office Expenses	43,000.00	36,813.07	6,186.93
Executive Travel	6,200.00	4,307.56	1,892.44
House Maintenance	42,600.00	35,108.85	7,491.15
Treasurer	14,200.00	11,954.57	2,245.43
Finance and Budget Committee	75.00	3.95	71.05
Secretary	500.00	—0—	500.00
Salary Taxes	23,104.35	20,338.93	2,765.42
Insurance	30,200.00	24,053.60	6,146.40
House Reserve	20,000.00	19,291.16	708.84
MSNJ Pension Plan	7,200.00	5,508.92	1,691.08
MSNJ Building Loan	11,700.00	9,750.00	1,950.00
MSNJ Computerized record keeping	24,000.00	1,987.17	22,012.83
MSNJ (New) Executive Offices	—0—	16,431.90	(16,431.90)
Legislation	16,000.00	15,556.53	443.47
Council on Public Health	3,800.00	2,816.89	983.11
Council on Public Affairs	117,700.00	110,663.61	7,036.39
Council on Medical Services	1,300.00	1,041.42	258.58
Council on Mental Health	1,800.00	394.27	1,405.73
President and Presidential Officers	30,000.00	19,487.86	10,512.14
AMA Delegates	31,200.00	29,416.10	1,783.90
MSNJ Auxiliary	9,700.00	8,529.88	1,170.12
Committee on Medical Education	30,900.00	22,466.11	8,433.89
Conference Groups	500.00	162.62	337.38
Membership Directory	35,000.00	45,211.28	(10,211.28)
Committee on Emergency Medical Care	11,200.00	10,984.83	215.17
Committee on Credentials	1,400.00	921.86	478.14
Committee on Medical Defense and Insurance	1,000.00	484.90	515.10
Membership Inquiry and Complaint Committee	1,000.00	711.10	288.90
Board of Trustees	11,500.00	6,098.17	5,401.83
Contingent	23,000.00	19,596.82	3,403.18
Judicial Council	1,000.00	346.12	653.88
Legal Expenses and Reserve Fund	13,000.00	3,000.00	10,000.00
CMDNJ-Foundation	10,000.00	10,000.00	—0—
Medical Student Loan Fund	6,000.00	6,000.00	—0—
Reimbursement for Representatives to Meetings	6,000.00	6,402.81	(402.81)
Total Budget Expenditures	<u>\$1,022,904.00</u>	<u>\$867,019.64</u>	<u>\$155,884.36</u>

Statement of Revenue and Expenditures
Medical Journal

	Ten Months Ended March 31, 1978 (Unaudited)	Year Ended May 31, 1977 (Audited)
Revenue:		
Members' Subscriptions	\$ 40,395.00	\$ 43,155.00
Advertising:		
United Media Associates	52,178.10	64,711.83
Local	19,420.04	20,715.00
Cooperative Rebate	—0—	—0—
Classified	854.40	1,022.45
Subscriptions and Extra Copies	2,718.96	2,080.83
Reprints—Net	11,770.95	5,024.74
Bad Debts Previously written off	—0—	130.36
Total Revenue	<u>\$127,337.45</u>	<u>\$136,840.21</u>
Expenditures:		
Publication	\$110,319.48	\$125,684.19
Salaries	36,767.99	40,743.07
Advertising Manager's Commission	4,716.38	7,903.63
Commissions—Local	11,449.72	11,858.48
Commissions—Agency UMA	7,862.63	9,879.67
Discounts	1,066.15	1,411.64
Payroll Taxes	2,281.67	2,702.82
Insurance	42.47	25.00
Travel	773.59	982.95
Office	862.06	1,085.49
Bad Debts	710.00	175.00
Total Expenditures	<u>\$176,852.14</u>	<u>\$202,451.94</u>
Excess of Expenditures over Revenue	<u>(\$ 49,514.69)</u>	<u>(\$ 65,611.73)</u>

Balance Sheet
Medical Student Loan Fund

	Ten Months Ended March 31, 1978 (Unaudited)	Year Ended May 31, 1977 (Audited)
Assets:		
Cash (Page Tr 27)	\$129,101.43	\$140,818.83
Notes Receivable — Secured by Life Insurance Policies Assigned	333,140.01	304,175.00
Loans Receivable — General Fund	45,971.58	45,215.81
Inventory — Fire Extinguishers	1,554.99	240.90
Fund Balance	<u>\$509,768.01</u>	<u>\$490,450.54</u>

Note: The Fund balance includes \$7,612.00 designated as the Albert Barker Kump Memorial Grant and \$5,055.00 designated as the Joseph E. Mott Memorial Grant.

Statement of Revenue and Fund Balance
Medical Student Loan Fund

	Ten Months Ended March 31, 1978 (Unaudited)	Year Ended May 31, 1977 (Audited)
Revenue:		
Contributions:		
General	\$ 3,185.00	\$ 4,741.16
General Fund Appropriation	6,000.00	6,000.00
Income from Savings and Certificates of Deposit	5,462.28	6,047.50
Interest on Notes Receivable	2,143.62	277.71
Interest on Loans Receivable — General Fund	2,250.00	2,970.00
Commissions	276.57	640.71
Total Revenue	<u>\$ 19,317.47</u>	<u>\$ 20,677.08</u>
Fund Balance, Beginning	<u>\$490,450.54</u>	<u>\$469,773.46</u>
Fund Balance, Ending	<u>\$509,768.01</u>	<u>\$490,450.54</u>

Reconciliation of State Assessment Account
For the Ten Months Ended March 31, 1978
(Unaudited)

Unearned Assessments, June 1, 1977		\$537,616.03
1978 Assessments — State Members' Dues Collection — (Paid Dues) (Page Tr 25)	\$763,080.00	
Accounts Receivable (Unpaid 1978 Dues)	<u>206,400.00</u>	
	\$969,480.00	
Less: 1978 Medical Journal Assessment	\$40,395.00	
1978 Annual Meeting Assessment	20,197.50	
	<u>\$ 60,592.50</u>	
	\$908,887.50	
1978 Affiliate Dues	<u>1,440.00</u>	
	\$910,327.50	
Less: 1978 Assessments applicable to Year Ending May 31, 1978		
\$910,327.50 x 7/12	<u>\$531,024.38</u>	
		<u>\$379,303.12</u>
Earned Assessments for the Ten Months Ended March 31, 1978		<u>\$916,919.15</u>

Schedule of State Assessments Collected
For the Ten Months Ended March 31, 1978
(Unaudited)

County	1978 Net Dues
Atlantic	\$ 18,360.00
Bergen	108,360.00
Burlington	26,640.00
Camden	48,480.00
Cape May	3,840.00
Cumberland	14,400.00
Essex	146,400.00
Gloucester	10,920.00
Hudson	33,120.00
Hunterdon	6,240.00
Mercer	23,400.00
Middlesex	49,440.00
Monmouth	37,560.00
Morris	47,280.00
Ocean	16,080.00
Passaic	66,000.00
Salem	4,440.00
Somerset	12,600.00
Sussex	7,680.00
Union	75,480.00
Warren	6,360.00
Total	<u>\$763,080.00</u>

Schedule of AMA Assessments Collected
For the Ten Months Ended March 31, 1978
(Unaudited)

County	American Medical Association Dues
Atlantic	\$ 28,000.00
Bergen	136,285.00
Burlington	35,250.00
Camden	81,500.00
Cape May	6,500.00
Cumberland	16,750.00
Essex	222,000.00
Gloucester	18,000.00
Hudson	46,875.00
Hunterdon	10,250.00
Mercer	47,375.00
Middlesex	61,000.00
Monmouth	28,750.00
Morris	66,500.00
Ocean	18,500.00
Passaic	57,250.00
Salem	8,500.00
Somerset	18,250.00
Sussex	7,250.00
Union	100,250.00
Warren	10,500.00
Total	<u>\$1,025,535.00</u>

Reconciliation of AMA Assessments
For the Ten Months Ended March 31, 1978
(Unaudited)

	American Medical Association
Balance Payable, June 1, 1977	\$ — 0 —
Assessments Collected per above Schedule	<u>1,025,535.00</u>
	\$1,025,535.00
Remitted to AMA	<u>\$1,025,535.00</u>
Balance Payable, March 31, 1978	<u>\$ — 0 —</u>

Schedule of NJFHCE Assessments Collected
For the Ten Months Ended March 31, 1978
(Unaudited)

County	New Jersey Foundation for Health Care Evaluation
Atlantic	\$ 1,760.00
Bergen	9,380.00
Burlington	2,330.00
Camden	4,180.00
Cape May	330.00
Cumberland	1,260.00
Essex	13,590.00
Gloucester	930.00
Hudson	3,850.00
Hunterdon	540.00
Mercer	2,680.00
Middlesex	4,560.00
Monmouth	4,160.00
Morris	4,180.00
Ocean	1,750.00
Passaic	5,630.00
Salem	390.00
Somerset	1,200.00
Sussex	660.00
Union	6,420.00
Warren	590.00
Total	<u>\$70,370.00</u>

Reconciliation of NJFHCE Assessments
For the Ten Months Ended March 31, 1978
(Unaudited)

Balance Unremitted Cash, June 1, 1977		\$ 20.00
Collections—1977 Accounts Receivable	\$ 6,480.00	
1978 Assessments (Above Schedule)	<u>63,890.00</u>	
		<u>\$70,370.00</u>
		70,390.00
Disbursements—N.J. Foundation for Health Care Evaluation		<u>30,170.00</u>
Balance: Unremitted Cash, March 31, 1978		\$40,220.00
Add: 1977 Accounts Receivable	\$ 980.00	
1978 Accounts Receivable	<u>17,200.00</u>	
		<u>\$18,180.00</u>
Total Due N.J. Foundation for Health Care Evaluation (Page Tr 21) March 31, 1978		<u>\$58,400.00</u>

Analysis of Professional Liability Account

	Ten Months Ended March 31, 1978 (Unaudited)	Year Ended May 31, 1977 (Audited)
Revenue:		
Mandatory Assessments	\$ 84,890.00	\$1,300,162.02
Less: Refunds	<u>(800.00)</u>	<u>(23,472.00)</u>
Total Assessments	<u>\$ 84,090.00</u>	<u>\$1,276,690.02</u>
Interest Earned:		
Savings Account	\$ 10,000.00	\$ 28,666.67
Investments	37,525.59	217.71
Note Receivable-NJSMUI	<u>6,059.97</u>	<u>3,279.42</u>
Total Interest Earned	<u>\$ 53,585.56</u>	<u>\$ 32,163.80</u>
Total Revenue	<u>\$ 137,675.56</u>	<u>\$1,308,853.82</u>

Professional Liability Account (cont'd)

Expenditures:

Cost of Collecting Mandatory Assessment	\$ 1,884.51	\$ 9,326.47
Cost of Professional Liability Update	3,564.75	9,410.58
Cost of Public Relations Advertising	32,025.80	93,403.41
Cost of Professional Services	42,192.00	86,864.50
Cost of American Health Systems Consultants	—0—	14,992.50
Cost of Malpractice Litigation Meeting	—0—	2,453.80
Cost of Printing Medico-Legal Seminar Booklets	—0—	3,897.00
Cost of Legislative Activities	23,100.00	1,650.00
Cost of American Arbitration Association	2,500.00	—0—
Cost of Other Expenditures	8,470.20	3,450.91
Total Expenditures	<u>\$ 113,684.26</u>	<u>\$ 225,449.17</u>
Excess of Revenue Over Expenditures	\$ 23,991.30	\$1,083,404.65
Beginning Fund Balance	<u>\$1,083,404.65</u>	<u>\$ —0—</u>
Ending Fund Balance (Page Tr 21)	<u><u>\$1,107,395.95</u></u>	<u><u>\$1,083,404.65</u></u>

Analysis of Cash, Investments and Income Thereon March 31, 1978 (Unaudited)

General Fund Cash	Cost	Yield	Interest Income
New Jersey National Bank:			
Treasurer's General Checking Account	\$ 4,289.21	—0—	\$ —0—
Savings Account #01-10-174556	392,511.67	5%	17,573.77
Trenton Savings Fund Society:			
Savings Certificate	20,000.00	6%	996.67
Savings Certificate	20,000.00	6.75%	1,121.25
Petty Cash on Hand	500.00	—0—	—0—
Total General Fund Cash	<u>\$437,300.88</u>		
Total Income from Savings			\$19,691.69
Less Credit for Professional Liability (Page Tr 26)			<u>10,000.00</u>
Income from Savings (Page Tr 22)			<u>\$ 9,691.69</u>

Portfolio Investments	Due Date	Maturity Value	Cost	Yield	Interest Income
U.S. Treasury Notes	6/30/78	\$ 60,000.00	\$ 59,943.75	6.875%	\$3,437.50
Federal Home Loan Bank	11/26/79	51,125.00	51,406.25	7.5%	3,107.95
Fed. Nat'l Mortgage Assn.	9/19/79	100,000.00	99,968.75	6.4%	5,317.05
Federal Land Bank	10/23/79	100,000.00	100,687.50	6.8%	5,626.58
U.S. Treasury Notes	7/31/79	40,000.00	39,853.00	6.25%	1,588.87
U.S. Treasury Notes	10/31/79	200,000.00	200,062.50	7.25%	5,719.55
Purchase Agreement					
N.J. National Bank	7/3/78	200,000.00	200,000.00	6.75%	3,217.81
Purchase Agreement					
N.J. National Bank	4/6/78	200,000.00	200,000.00	6.6%	880.00
U.S. Treasury Bills	8/31/78	40,000.00	38,643.20	6.709%	190.67
		<u>\$991,125.00</u>	<u>\$990,564.95</u>		

Income from Portfolio Investments Redeemed During Period	\$22,597.95
	<u>\$51,683.93</u>
Less: Credit for Professional Liability Interest Income Earned (Page Tr 26)	<u>37,525.59</u>
Income from Portfolio Investments (Page Tr 22)	<u>\$14,158.34</u>

Medical Student Loan Fund Cash	Cost	Yield	Interest Income
New Jersey National Bank:			
Treasurer's Checking Account	\$ 73.66	—0—	\$ —0—
Savings Account #01-10-205566	129,027.77	5%	5,462.28
Total Income (Page Tr 24)	<u>\$129,101.43</u>		<u>\$ 5,462.28</u>

Filed in accordance with the recommendation of the Reference Committee

Finance and Budget

Richard E. Lang, M.D., Chairman, Passaic
(Reference Committee "B")

A review of the expenses of the first ten months of the current administrative (fiscal year) and an estimation of the expenses for the final two months indicate that the individual budget accounts are sound.

THE JOURNAL AND ANNUAL MEETING EXPENSE

The (net) *Journal* deficit is anticipated to be lower, mainly due to the fact that this will be the sixth year that a per capita assessment designated for each member's *Journal* subscription rate will be applied. However, the dues allocation to the *Journal* will be increased from \$5 per member to \$10 per member for 1978, whereas it was \$5 or one-half of the subscription rate for 1977.

There are other factors contributing to the anticipated decrease in the net deficit which are (1) the introduction, effective with the March, 1978 issue, of new graphics which result in an overall increase of usable *Journal* page space by 30 per cent and augment the continuity and simplicity of the appearance of *The Journal*; (2) the consolidation of the Annual Reports and actions of the House of Delegates into one report. The July transaction issue of *The Journal* will still be known as such but will be the 13th issue of *The Journal* relating the Annual Reports and actions of the House of Delegates, thus, returning to *The Journal* the July as well as the April issues for exclusive *Journal* usage; (3) the results from engaging a new printer (January 1977), with the use of lighter weight inside paper stock and economical web presses, have leveled off production costs; and (4) a four-state *Journal* readership study currently under way, hopefully, will give us results that further will assist in our efforts to reduce and control the annual deficit incurred on *The Journal*.

Your Committee recommended, with the concurrence of the Board of Trustees, that the 1979 assessment include a \$10 and \$5 per capita assessment designated respectively for each member's *Journal* subscription rate, and Annual Meeting registration rate, that the full amounts realized as of May 31, 1979 be applied in 1979, and that the Committee on Finance and Budget be called upon to review these allocations annually.

Your Committee was cognizant of the fact that the above action will not discharge completely the deficits experienced each year in these two accounts. Nevertheless, the net deficit in each account will be considerably less and will be charged to the unexpended balance of the fiscal budget and/or the balance of the General Fund.

MEDICAL EDUCATION AND THE ACADEMY OF MEDICINE OF NEW JERSEY

Your Committee again has approved, with the concurrence of the Board of Trustees, the inclusion of \$25,000 in the budget of the Committee on Medical Education for 1978-79 for the Academy of Medicine of New Jersey for post-graduate educational programs and activities, with the continued proviso that the Committee on Medical Education, with the concurrence of the Board of Trustees, be empowered to expend up to this amount in the course of the administrative (fiscal) year on the basis of need reflected in the 1978-79 fiscal report to be submitted by the Academy of Medicine of New Jersey to the Committee on Finance and Budget.

NEW JERSEY FOUNDATION FOR HEALTH CARE EVALUATION

Your Committee has approved, with the concurrence of the Board of Trustees, the proposed 1978-79 budget prepared by the Finance Committee of the New Jersey Foundation for Health Care Evaluation. The budget totals \$214,718.00.

IPA/HMO CONSORTIUM

Your Committee has approved, with the concurrence of the Board of Trustees, the funding by the Medical Society of New Jersey, for one year, of the IPA/HMO Consortium. It would consist of all County Medical Societies, New Jersey Osteopathic Society, industry and other interested parties whose purpose would be to provide support and information regarding the formation and management of IPA/HMO.

1979 ASSESSMENT

The computation of General Fund Balance at the close of the 1977-78 Fiscal Year is estimated at \$216,688.05 — 10.76 percent below the \$240,000 sum approved, with the concurrence of the Board of Trustees as the desired minimal surplus.

In accordance with Chapter X of the Bylaws, the dues year is January 1 to December 31, and the fiscal year is June 1 to May 31. The administrative year including the budget which controls expenditures, is based on the fiscal year. It therefore becomes necessary to apportion the 1978 and 1979 per capita assessment to the 1978-79 Fiscal Year on the basis of 7/12 of the 1978 assessment for the new fiscal year soon to commence (June 1, 1978) and 5/12 of the 1979 assessment for the latter part of that Fiscal Year starting January 1, 1979.

The following is the computation of the General Fund Balance and the determination of the 1979 assessment:

Proposed Budget for 1978-79	\$1,126,091.00
7/12 of 1978 assessment applicable to	
1978-79 Budget	<u>\$31,152.71</u>
Amount to be raised by 5/12 of 1979 assessment	<u>\$ 594,938.29</u>
\$172.45 x 8,280 members paid = \$1,427,886.00	
x 5/12	\$ 594,952.50
Amount to be raised with General Fund Balance	
over \$240,000 applied to budget excess at	
5/31/78, estimated	\$ (23,311.95)
Amount needed to round out the per capita	
assessment from \$172.45 to \$173.00	<u>\$ 1,911.71</u>
Remainder of General Fund Balance in excess	
of \$240,000	\$ (21,400.24)
Add the required General Fund Balance	<u>\$ 240,000.00</u>
Estimated adjusted cash surplus at 5/31/78	<u>\$ 218,599.76</u>
\$173 x 8,280 members paid = \$1,432,400	
x 5/12	\$ 596,850.00
plus the amount raised from General Fund	
Balance	<u>\$ (1,911.71)</u>
Amount to be raised to meet 5/12 requirement	<u>\$ 594,938.29</u>
For each \$1,000 increase in the proposed budget add .29c to assessment.	
For each \$1,000 decrease in the proposed budget subtract .29c from assessment.	

1978-79 BUDGET

The proposed budget for 1978-79 totals \$1,126,091. It is the opinion of the Committee that the budget should adequately provide the necessary funds for the efficient operation of the Society's business during the coming year. It is not to be assumed that all sums budgeted necessarily will be utilized.

As requested by the House of Delegates, your Committee is listing explanatory footnotes on accounts which show a marked difference between current and proposed budgets.

Your Committee has included as an addendum the 1978 dues assessment for the fifty state societies, the District of Columbia, Puerto Rico, and the Canal Zone as published by the AMA.

RECOMMENDATIONS

(1) That the Budget for 1978-79 be adopted in the total sum of \$1,126,091.

Approved in accordance with the recommendation of the Reference Committee.

(2) That the 1979 assessment be adopted at \$173 per capita, with no provision for a contribution to AMA-ERF. The dues assessment will cover a budget allocation, for the tenth consecutive year, to the Academy of Medicine of New Jersey which eliminates the need for special assessment therefor. The dues assessment also will cover a budget allocation, for the fifth year, to the Inter-Agency Commission on Emergency Medical Care and, for the third year, a budget allocation to the Foundation of the College of Medicine and Dentistry of New Jersey. Of the \$173 per capita assessment, \$10 and \$5 will be designated respectively for the member's

Journal subscription and Annual Meeting registration; and the full amounts realized as of May 31, 1979, will be applied in 1979.

Approved in accordance with the recommendation of the Reference Committee.

(3) That a special assessment be adopted at \$20 per capita, to serve as a grant to the New Jersey Foundation for Health Care Evaluation; that this special per capita assessment be set in addition to and not as part of the budgetary assessment; and that both be paid at the same time.

Approved in accordance with the recommendation of the Reference Committee.

(4) That a special assessment be adopted at \$7 per capita, to serve as MSNJ's contribution for the IPA/HMO Consortium's first year of operation; that other participating groups in the Consortium made proportionate similar contributions; that this special per capita assessment be set in addition to, and not part of, the budgetary assessment; that all be paid at the same time.

Approved in accordance with the recommendation of the Reference Committee.

(5) That the 1979 assessment be set at \$20 per capita for affiliate and associate members as it was for 1978 and for 1977.

Approved in accordance with the recommendation of the Reference Committee — The assessment for medical students was set at \$5.

Account	Current Budget 1977-78	Footnotes	Proposed Budget 1978-79
A- 1—Executive Salaries	\$145,327.00	(1)	\$ 159,570.00
A- 2—General Staff Salaries	291,797.65	(1)	352,520.99
A- 3—Gen. Exec. Office Expenses	43,000.00	(2)	45,000.00
A- 4—Executive Travel	6,200.00	(3)	8,100.00
A- 5—House Maintenance	42,600.00	(4)	47,000.00
A- 6—Treasurer	14,200.00		14,600.00
A- 7—Finance and Budget	75.00		75.00
A- 8—Secretary	500.00		500.00
A- 9—Salary Taxes	23,104.35	(10)	32,104.01
A-10—Insurance	30,200.00	(5)	35,200.00
A-11—House Reserve	20,000.00	(6)	23,000.00
A-12—MSNJ Pension Plan	7,200.00		7,200.00
A-13—MSNJ Building Loan	11,700.00		10,800.00
A-14—MSNJ Computerized Record Keeping	24,000.00		24,000.00
A-15—MSNJ (New) Executive Offices	—0—	(7)	226,000.00
C- 2—Legislation	16,000.00	(8)	11,000.00
C- 3—Public Health	3,800.00	(9)	4,200.00
C- 4—Public Affairs	117,700.00	(9)	118,100.00
C- 5—Medical Services	1,300.00	(9)	2,000.00
C- 6—Mental Health	1,800.00	(9)	1,800.00
D- 1—President and Presidential Officers	30,000.00	(10)	28,000.00
D- 2—AMA Delegates	31,200.00	(10)	27,000.00
D- 3—MSNJ Auxiliary	9,700.00		9,500.00
D- 4—Medical Education	30,900.00	(11)	30,600.00
D- 5—Conference Groups	500.00		500.00
D- 6—Membership Directory	35,000.00	(12)	46,471.00
D- 7—Emergency Medical Care	11,200.00	(13)	6,400.00
D- 8—Credentials	1,400.00		1,400.00
D-11—Medical Defense and Insurance	1,000.00		1,000.00
D-12—Membership Inquiry and Complaint	1,000.00		1,000.00

E- 1—Board of Trustees	11,500.00	(9)	13,000.00
E- 2—Contingent	23,000.00		23,000.00
E- 3—Judicial Council	1,000.00		1,000.00
E- 4—Legal Expense and Reserve Fund	13,000.00		13,000.00
E- 5—CMDNJ—Foundation	10,000.00		10,000.00
E- 6—Medical Student Loan Fund	6,000.00	(14)	3,000.00
E- 7—Authorized Reimbursement for Representatives to Meetings	6,000.00	(9)	7,200.00
Totals	<u>\$1,022,904.00</u>		<u>\$1,344,841.00</u>
Less: Internal Adjustments			<u>218,750.00</u>
Revised Proposed 1978-79 Budget			<u><u>\$1,126,091.00</u></u>

(1) Increased due to increments granted to both executive and general personnel.

(2) Increased to cover higher luncheon cost, leasing of a Xerox/Cheshire 730 Addressing System, IBM Copier, and preventive maintenance agreements.

(3) Increased to cover Executive Staff travel and expenses at off-premises educational meetings.

(4) Increased to cover the leasing, maintenance, and insurance of one Auto-Van.

(5) Increased to cover higher expenses anticipated under the insurance program for the MSNJ Personnel.

(6) Increased to cover anticipated capital equipment purchases.

(7) Establishes an account to cover MSNJ's New Executive Offices which covers Mortgage payments, Property Taxes and insurance, and other operating costs.

(8) Decreased because of the elimination of budgeting for a legislative consultant and reduction of soft-dollar for JEMPAC.

(9) Increased to cover higher anticipated specific expenses charged to this account.

(10) Decreased because the 1978 AMA Annual Convention is being held in St. Louis, Missouri and 1978 AMA Interim Meeting will be held in Chicago.

(11) This account provides for the Medical Education Committee, with the concurrence of the Board of Trustees, to expend up to \$25,000 in the course of the administrative year (1978-79) to the Academy of Medicine of New Jersey for post-graduate educational programs and activities, on the basis of need reflected in the fiscal report to be submitted by the Academy to the Committee on Finance and Budget.

(12) Increased to cover higher anticipated publishing cost associated with the 1978-79 edition of the *Membership Directory*.

(13) Decreased because for 1978-79 an allocation of \$5,000 is provided for the Inter-Agency Commission on Emergency Medical Care.

(14) Decreased to provide for two \$1,500 Medical Student Loans should the need arise for this allocation during the 1978-79 Fiscal Year.

State Medical Society Dues—1978*

1. Idaho	\$310.00	27. Indiana	\$181.00
2. Alaska	300.00	28. Texas	180.00
3. South Dakota	300.00	29. Florida	175.00
4. Wisconsin	300.00	30. Rhode Island (1979)	175.00
5. Wyoming	300.00	(excluding Special Assessments)	
6. District of Columbia	295.00	31. California	165.00
7. Colorado	285.00	32. Maryland	160.00
8. Iowa	275.00	33. Nevada	160.00
9. Arizona	250.00	34. New Hampshire	150.00
10. Hawaii	240.00	35. North Dakota	150.00
11. Arkansas	225.00	36. Oklahoma	150.00
12. Georgia	225.00	37. West Virginia	150.00
13. Kentucky	225.00	38. Washington	147.00
14. Minnesota	225.00	39. North Carolina	140.00**
15. Pennsylvania	225.00	40. Puerto Rico	140.00
16. South Carolina	220.00	41. New Mexico	135.00
17. Oregon	212.50	42. Illinois	131.00
18. Delaware	205.00	43. Tennessee	130.00
19. Louisiana	200.00	44. Vermont	130.00
20. Maine	200.00	45. Alabama	125.00
21. Mississippi	200.00	46. Kansas	125.00
22. Montana	200.00	47. Ohio	125.00
23. Nebraska	200.00	48. New Jersey (1978)	120.00
24. New York (1979)	200.00	49. Missouri	115.00
(including Special Assessments)		50. Massachusetts	110.00
25. Utah	195.00	51. Virginia	105.00
26. Michigan	190.00	52. Connecticut	100.00
53. Canal Zone			18.00

*Average Dues—1978—\$190.00
1977—\$158.00

(does not include Canal Zone)

**New members pay \$165.00 first five years.

The recommendations on page Tr 29 were adopted in accordance with the recommendation of the Reference Committee and the report as a whole was filed.

Medical Student Loan Fund

William Greifinger, M.D., Chairman, Newark

(Reference Committee "B")

In its twenty-one years of operation the Medical Student Loan Fund has granted loans totaling \$536,255.65 including \$444.35 as insurance payments, bringing the net loans granted to \$536,700.

To date the Fund has issued 436 loans to 269 New Jersey medical students. One hundred and seventy-six loans have been repaid in full. Eighteen borrowers presently are making quarterly repayments on an annual basis.

Thirty-five requests for financial assistance by New Jersey medical students were received during the 1977-78 administrative year, and thirty loans in the amount of \$1,500 each were granted for a total of \$45,000. It is expected that this trend will continue for some time.

It is estimated that the Fund will have \$42,745 available for loans for the 1978-79 school year to accommodate twenty-eight students at \$1,500 each. Of this amount \$13,500 is committed to nine reapplicants and \$13,500 to

nine new student applicants, leaving a balance of \$15,745 for anticipated applications from ten additional new students.

This report does not reflect all the anticipated applications from other qualified medical students. Your Committee is mindful of the ever-increasing tuition rates; however, at this time, it does not feel it can afford to increase the \$1,500 yearly loan limit.

Your Committee has had continued encouraging results from its solicitation of past loan recipients, now serving an internship or residency, to initiate early repayment of their loans on an interest-free basis. This year seventeen loans have been paid in full, a total of \$19,000. The financial activities of the Fund during the year are included in the report of the Treasurer.

Your Committee warmly commends Mr. Lambert, Mr. Squireck, and the student interviewers for their consistently efficient administrative assistance.

CONTRIBUTIONS

The Committee is grateful to the many contributors to the Fund, and takes this occasion to acknowledge their support. A list of contributors since the last report follows:

(1) General Fund:

Medical Society of New Jersey, Board of Trustees; MSNJ's Auxiliary Executive Board; Passaic County Medical Society, County Auxiliaries: Burlington, Camden, Cape May, Essex, Gloucester, Hudson, Mercer, Middlesex, Ocean, Passaic, Salem, and Warren. Bob and Louise Brabston, Bessie I. Butler, Dr. and Mrs. Robert Cornwell, Dr. and Mrs. Philip Fiscella, Evelyn Gorus, Dr. and Mrs. Elmer Grimes, Faye and Arthur Gross, Maureen Hackett, Dr. and Mrs. I. R. Hayman, Joseph R. Jehl, M.D., Dr. and Mrs. John Kustrup, Dr. and Mrs. Samuel J. Lloyd, Dr. and Mrs. Donald McLean, Charles F. Mess, M.D., Ms. Norma R. Miller, Dr. and Mrs. Paul H. Pettit, Emanuel M. Satulsky, M.D., Dr. and Mrs. A. L. Semet and Family, Mrs. Lucius S. Tarchiani, Dr. and Mrs. Franklin Thelmo, Shirley M. Walsh, Dr. and Mrs. Carl N. Ware, Dr. and Mrs. Ralph B. Wayman, Jr., Margaret Wolfe, Yardley-Makefield Lions Club

(2) In Memory of:

Martin J. Ackerhalt, M.D., Mrs. Mary Morrison Ash, Joseph

Baldino, John H. Banks, Jr., Anthony Barbiera, Norbert Beim, M.D., Mrs. Louise H. Camwell, John Conaris, M.D., Malcolm E. Cooper, Mrs. Walter Corrigan, Millard Cryder, M.D., Harold L. Davis, M.D., Luz Dean, Arthur Devlin, M.D., David Doktor, M.D., Mrs. Ferdinand Engelhart, Mr. Julius Fernandez, Salvatore T. Ferrari, M.D., Paul J. Finegan, M.D., John Kent Finley, M.D., Clarence Fuhrman, Mrs. Katherine Haggerty, Rafael A. Jacobo, M.D., Marie Jehl, Evelyn Stols Joule, Sidney Keats, M.D., Victor M. Kimel, M.D., Dorothy K. Klughaupt, M.D., Elton W. Lance, M.D., Seraphina Byrne Leech, Francis J. McCauley, M.D., Mrs. Lucy McDonough, Norman Meyers, M.D., Correinne L. Miller, Harrold A. Murray, M.D., Johannes F. Pessel, M.D., J. Charles Popkin, Cornelius J. Regan, M.D., Steve Richards, Ettore G. Rizzo, M.D., Jose Rosales, M.D., Mrs. Walter G. Scheuerman, Saul Siegendorf, M.D., Mrs. R. Snierski, Mrs. May Spinack, Mrs. Abigail Shiffert, Henry S. Urbaniak, M.D., Mrs. Frank Williams.

(3) In Honor of:

Medical Society of New Jersey, Board of Trustees; Elliott Eisenstein, Mrs. David Gehring, Matthew C. Kartch, M.D., MSNJ's Auxiliary Executive Board, Dr. Robert Pinck's Election to the Football Hall of Fame, Lawrence J. Pizzo, M.D., Saul L. Sanders, M.D., Bernard Simon, M.D., Mrs. Lucius Tarchiani, Abraham H. Topchick, M.D., Richard A. Walzer, M.D.

PRESENT LOCATION OF RECIPIENTS OF LOANS

The 125 graduates are located as follows:

Interns—16 in New Jersey and 15 out-of-state	31
Residents—17 in New Jersey, 29 out-of-state, 1 in Canada, and 1 in England	48
Armed Service—1 Army of the United States, 2 United States Navy, and 1 United States Air Force	4
Private Practice— 2 Arizona	4 California

2 Connecticut	2 Florida
1 Illinois	1 Indonesia
2 Massachusetts	12 New Jersey
6 New York	1 Ohio
5 Pennsylvania	1 South Carolina
3 Virginia	42
Students presently in medical school—21 seniors, 7 juniors, and 2 sophomores	30
Current Student Loans Outstanding	155
Medical Students Paid in Full (179 loans)	114
Total New Jersey Medical Students (as listed earlier)	269

DISTRIBUTION OF LOANS

County of Residence	Medical School	Students	Loans Granted	
			1957-77	1977-78 March 31, 1978
Atlantic	Hahnemann	3	\$ 3,000	
	N.J. Medical	1	1,000	
	Pittsburgh	1	2,000	
	Temple	1	1,000	
	Tufts	1	4,000	
Bergen	Albert Einstein	1	3,000	
	Boston	1	1,000	
	Creighton	1	1,000	
	Hahnemann	3	5,000	
	Jefferson	3	7,500	
	Loyola-Stritch	1	3,000	
	Med. Coll. Pa.	1	3,000	
	N.J. Medical	11	15,500	\$ 1,500
	N.Y. Medical	3	5,500	
	Rutgers	3	3,000	1,500
	St. Louis	2	3,000	
Burlington	Tufts	2	3,000	1,500
	U. of Pa.	1	3,000	
	Duke	1	4,000	
	Georgetown	1	3,000	
	Hahnemann	2	4,000	
Camden	Jefferson	3	9,500	
	Med. Coll. Pa.	1	1,500	
	Albert Einstein	2	1,500	1,500
	Hahnemann	5	9,500	
	Jefferson	4	6,500	1,500
Cumberland	Michigan	1	2,000	
	N.J. Medical	2	2,700	
	Penna. U.	1		1,500
	Temple	5	7,500	
	Tufts	1	3,000	
Essex	Jefferson	1	2,000	
	Albany	1	4,000	
	Bern	1	2,000	
	Creighton	3	6,000	1,500
	Duke	1	2,000	
	Emory	1	1,500	1,500
	Georgetown	4	4,000	1,500
	Hahnemann	4	9,500	
	Howard	1	300	
	Jefferson	1	3,000	
	N.J. Medical	27	51,900	4,500
	N.Y. Medical	2	2,000	
	Stanford	1	3,000	
	St. Louis	1	500	
	Temple	1	1,000	
	Tufts	4	4,500	3,000
	Wisconsin	2	1,500	1,500
	Yale	1		1,500
Gloucester	Hahnemann	1	1,000	
	Temple	1	2,000	
	Virginia U.	1	1,000	
Hudson	Boston	1	3,000	
	CMDNJ-5th Channel	1	1,500	
	Georgetown	1	1,000	
	George Washington	1	3,000	
	Hahnemann	1	1,500	
	Harvard	1	1,000	
	Howard	1	400	
	Med. Coll. Pa.	2	1,500	1,500
	N.J. Medical	22	37,650	
	N.Y. Medical	1	1,000	
	Pittsburgh	1	3,000	
Hunterdon	St. Louis	1	2,000	
	Hahnemann	1	3,000	
	Rutgers	1	1,500	

Mercer	CMDNJ-5th Channel	2	3,000	
	Georgetown	2	4,500	
	Hahnemann	5	7,500	1,500
	Howard	1	1,000	
	Johns Hopkins	1	1,000	
	Louisville U.	1	4,500	
	Meharry	1	250	
	Mississippi	1	3,000	
	N.J. Medical	6	9,500	1,500
	N.Y. Medical	1	1,500	
	Penna. U.	1	1,000	
	Rutgers	1	1,500	
	St. Louis	1	700	
	Tufts	1	3,000	
	Wisconsin	1	1,500	
Middlesex	Georgetown	3	3,000	1,500
	Hahnemann	1	4,000	
	Loyola-Stritch	1	1,500	
	N.J. Medical	2	3,000	
	N.Y. Medical	2	4,500	
	Rutgers	1	3,000	
	Wisconsin	1	1,500	
Monmouth	Albert Einstein	1	1,500	
	Bowman Gray	1	1,500	
	Columbia	1	2,000	
	Duke	1	3,000	
	Georgetown	2	1,000	1,500
	Hahnemann	2	1,500	1,500
	Jefferson	2	6,000	
	Loyola-Stritch	1	4,500	
	Marquette	2	3,500	
	Med. Coll. Pa.	1	1,500	
	N.J. Medical	3	10,000	
	N.Y. Medical	1	4,000	
	Temple	1	2,000	
	Up-State N.Y.	1	1,000	
Morris	Albany	2	1,500	1,500
	Case Western	1	3,000	
	Dartmouth	1	1,000	
	Duke	1	1,000	
	George Washington	2	1,500	1,500
	Loyola-Stritch	1	1,500	
	Michigan	1	1,500	
	N.J. Medical	4	7,500	1,500
	Rush	1		1,500
	Tufts	1	1,500	
Ocean	Med. Coll. Pa.	1	3,000	
	Rutgers	1	3,000	
	SUNY-Downstate	1	1,500	
	Tufts	1	3,000	
Passaic	Jefferson	1	3,000	
	N.Y. Medical	2	2,500	
	Wisconsin	2	3,000	
Salem	Duke	1	1,500	
	Jefferson	1	3,000	
Somerset	Georgetown	1	1,000	
	N.Y. Medical	1	2,000	
	Temple	1	3,000	
	Western Reserve	1	1,000	
Union	CMDNJ-5th Channel	1	1,500	
	Cornell	1		1,500
	Florida	1	1,000	
	Georgetown	3	4,500	1,500
	Hahnemann	3	5,500	
	Jefferson	3	7,500	1,500
	Johns Hopkins	1		1,500
	N.J. Medical	12	20,800	
	N.Y.U.	2	4,500	
	Wisconsin	1	3,000	
18 Counties	43 Medical Schools	281	\$491,700	\$ 45,000
Total Loans Granted 3/31/78				\$536,700

RECOMMENDATIONS

1. That the House of Delegates concur in the recommendation of the Finance and Budget Committee—approving a budget appropriation of three thousand dollars in lieu of a special per capita assessment for 1978-79 in support of the Medical Student Loan Fund.

Approved in accordance with the recommendation of the Reference Committee.

2. That the MSNJ membership be urged to continue its

active support by sending contributions to the Fund.

Approved in accordance with the recommendation of the Reference Committee.

3. That the Medical Society of New Jersey Auxiliary be requested to make the Fund its number one project next year.

Approved in accordance with the recommendation of the Reference Committee.

Report as a whole filed in accordance with the recommendation of the Reference Committee.

Publication

Daniel B. Roth, M.D., Chairman, Teaneck

(Reference Committee "B")

There have been many significant *Journal* activities during the present reporting period. The most important are as follows:

1. The Board decided to publish the Annual Meeting Program (April) and the Transactions (usually July) as separate supplements. This means that all twelve issues of *The Journal* will be "regular," containing scientific articles and the other usual sections.

2. As a result of a consultation with Paul Fisher, Professor of Journalism at the University of Missouri, *The Journal* will display a major change in format starting with the spring of this year. The graphics, typography, and space utilization have been modified in the interest of readability, eye-appeal, and economy. The "new look" should be most

attractive.

3. *The Journal* has had an increase in advertising revenue. Our media representatives attribute this to the overall quality of our publication.

4. In order to remain current and responsive, a readership survey is being implemented. This should provide guidelines for future changes in accordance with our policy of providing our readers with the kinds of material they want.

5. *The Journal* will conform with the Copyright Revision Act of 1976, effective January 1, 1978. The essential facts are as follows:

(a) The Medical Society of New Jersey will maintain copyright ownership on all material published. Each author will be required to assign copyright ownership to the Medical Society of New Jersey before publication of his material.

(b) Individuals, universities, libraries, and other non-profit organizations will be permitted to photocopy articles in *The Journal* for non-commercial, educational purposes.

Filed in accordance with the recommendation of the Reference Committee.

REFERENCE COMMITTEE "C"

Frank J. Hughes, M.D., Camden
Chairman
Benjamin Wolfson, M.D., Gloucester
Emile J. Berlet, M.D., Bergen
Samuel C. Ingraham, M.D., Cape May
John Winslow, M.D., Essex
Thomas J. Connolly, Jr., M.D., Hudson
Alternate Member

Reports:
Board of Trustees' Items
Medical Inter-Insurance Exchange
of New Jersey
Medical-Surgical Plan of New
Jersey
Committee on Medical Defense
and Insurance
Committee on Retirement Plan
for Physicians
Resolutions #4, #5

Board of Trustees' Items

DEDUCTIBILITY OF SURPLUS PAYMENT **(Reference Committee "C")**

It was noted that it is Legal Counsel's opinion that payments to the Medical Inter-Insurance Exchange of monies kept in a running account for the duration of membership in the Exchange are deductible as a business expense; however, there are no identical cases on record and the opinion is purely advisory.

MSNJ has authorized the forwarding of information on this query to IRS for determination. Should IRS not allow the deduction the decision will be appealed.

Filed in accordance with the recommendation of the Reference Committee.

JOINING THE MEDICAL INTER-INSURANCE **EXCHANGE** **(Reference Committee "C")**

The 1977 House of Delegates considered a resolution from the Morris County Medical Society which called upon the Medical Society of New Jersey and the Board of Directors of MIIIE to do all in their power to get the acceptance of the Commissioner of Insurance of New Jersey of a plan whereby there would be a certain percentage reduction in the yearly premium payment for those physicians in the MIIIE plan who are members of MSNJ or of the New Jersey Society of Osteopathic Physicians and Surgeons.

Upon referral to the Insurance Underwriters of MIIIE for study and evaluation it was determined that the resolution could not be implemented because it violates Federal and State laws.

Filed in accordance with the recommendation of the Reference Committee.

PHYSICIANS STARTING PRACTICE IN NEW JERSEY **(Reference Committee "C")**

Resolution #18, from the 1977 House of Delegates, called upon the Society to investigate ways that a fund could be established by the Insurance Exchange to loan the first year's premiums and surplus capitalization monies to all physicians just completing residency training who are about to establish a practice of medicine or surgery in New Jersey, to be paid back over a period of three years without interest. MSNJ and the Exchange have developed a system to address this issue.

Resolution #30 was referred to the Insurance Underwriters of MIIIE for study. Those portions able to be accomplished without legislation are to be effected via management implementation by the Underwriters. Those subject to adoption via the Rule of Court are being considered via the Supreme Court Committee. The item concerning periodic payments is being placed in the new liability package.

Filed in accordance with the recommendation of the Reference Committee.

New Jersey State Medical Underwriters, Inc. Medical Inter-Insurance Exchange of New Jersey

Vincent A. Maressa, Secretary/Treasurer

(Reference Committee "C")

The New Jersey State Medical Underwriters and the Medical Inter-Insurance Exchange of New Jersey completed their first policy year on January 31, 1978, with 5,070 insured physicians. There have been 210 reported incidents. Forty-five of these are viewed as having no potential for claim, 63 are considered as potential claims requiring a reserve, 52 are actual claims with reserves, and 13 are actual suits with reserves. There have been 37 closed cases which resulted in 22 paid claims and 15 closed without payment. Total costs on the 22 paid cases were \$25,600.00. Outstanding reserves on the open cases are 1.45 million dollars. The performance thus far is in accord with the anticipated actuarial trend.

Two segments of the operation of the Underwriter warrant further elaboration in this report.

Claims Management Committee

This Committee consists of three physicians and the Director of Claims Administration. It reviews the work of the Claims Department and conducts an individual review of all significant cases. Some of the innovative management techniques being utilized are:

a. A computer program which collects data while reducing paperwork, thus allowing claims staff to devote 90 percent of its time to claims management. The system also gives instant access to files in a manner that permits optimum analysis of facts and issues vital to proper evaluation and response.

b. Duplication of defense attorneys' files has been discontinued. Claims personnel abstract directly from counsel's files, telephone in relevant summaries, and picture copy only essential documents.

c. Claims personnel assist defense counsel in preparing

very specific interrogatories, thus avoiding "canned" forms and repetitious filings.

d. Peer review panels have been established to assist in investigations and evaluation of cases within weeks of the first report. Over 1,500 physicians have volunteered their services in this regard.

Underwriting Committee

This Committee consists of six physicians plus the Director of Underwriting. It is responsible for monitoring the Underwriting Department, for reviewing all denials, for considering the imposition of surcharges, limit restrictions, and class determinations.

The Committee has effected a working liaison with the specialty societies and invites their representatives when a problem affecting one of their members is under consideration.

Our appreciation is extended to Mr. Peter Sweetland and his staff for the startling accomplishments and progress made thus far. Likewise, recognition must be given to Dr. James S. Todd and Dr. Elmer J. Grimes, and all the physicians serving the Underwriter and the MIE of New Jersey. Their performance, cooperation, and dedication has been simply outstanding. The keystone to all of this is the 5,070 physicians who have placed their faith, finances, and future in the Medical Inter-Insurance Exchange of New Jersey and the New Jersey State Medical Underwriters, Inc.

Copies of the annual report of the Medical Inter-Insurance Exchange of New Jersey may be secured by writing or calling the Office of the Underwriter in Lawrenceville, New Jersey.

Filed in accordance with the recommendation of the Reference Committee.

Medical-Surgical Plan of New Jersey

Joseph P. Donnelly, M.D., President, Newark

(Reference Committee "C")

The year 1977 was one of introspection and planning for the future by Blue Shield of New Jersey.

The expectations and needs of our subscribers and the medical profession, the rising costs of medical care, continuing general inflation, the determination that more health and consumer education is needed, the increasing interest of the public in a healthy lifestyle—all were factors to be examined and considered in determining how we could continue to be "the best buy" in medical insurance for New Jersey consumers.

TWO MAJOR NEW PROGRAMS DEVELOPED

Out of our self-examination came two new major benefit programs and a consumer education campaign which were to be introduced in early or mid 1978.

The new programs are the Series 14/20, a higher-payment, fixed-fee program which will extend paid-in-full service benefits to a larger portion of our subscribers and a new Blue Shield dental benefit program available to groups of 25 or more subscribers.

Planning for these programs involved the board and its committees, officers, directors, and task force members from various disciplines within the Plan.

The Series 14/20 program will have payments some 40 percent higher than those in the Series 750 program. The income levels for eligibility for paid-in-full service benefits will be \$14,000 for single, unmarried subscribers and \$20,000 for husband-wife income.

In addition, the Series 14/20 program will feature Blue Shield's first easy-to-understand contract.

It is our belief that this higher-payment program will be well received by the public and the medical profession.

The New Jersey Blue Shield Dental Program provides an incentive for frequent visits to the dentist, which helps overcome neglect—the most common cause of dental disease. Based on a building-block approach that allows groups to choose programs to suit their needs and their budgets, the dental program covers basic dental needs before they become major problems. The program's basic component covers the most frequently used dental services, such as simple extractions, fillings and periodic exams. Options are available to cover more complex services such as dentures, bridges, and straightening of teeth.

CONSUMER EDUCATION ON PAID-IN-FULL SERVICE BENEFITS

It was determined that more intense consumer education was needed on the subject of paid-in-full service benefits and participating physicians. The public must continue to be helped to understand how participating physicians benefit them. Consequently, in mid-1978 an innovative educational campaign will be inaugurated. This will include a special 800 telephone line through which subscribers can find out whether their physician is a participating physician. We will tell the patients to choose their physician carefully and to discuss charges in advance of service whenever possible to avoid any unpleasant surprises. Participating physicians who provide paid-in-full service benefits to eligible subscribers continue to be the unique feature of Blue Shield. Without participating physicians and service benefits we would be just another insurance company.

INCREASED NUMBERS OF PARTICIPATING PHYSICIANS

During 1977, a total of 465 new physicians and providers became participating, bringing the total number to 8,894 in the fixed-fee programs and 7,700 in the Usual, Customary or Reasonable (UCR) Fee program.

PROFESSIONAL RELATIONS EXPANDED

In a continuing effort to enhance communication between ourselves and the medical profession, our professional relations staff increased the number of office visits and field contacts during 1977 to a total of 1,660 office visits and meetings with 3,140 doctors and their office assistants. There also were 35 hospital-based meetings with 1,359 physicians and providers and their office staffs. The field staff also held 23 meetings with 611 medical assistants and vocational students.

Our professional relations inquiry unit answered some 39,000 telephone calls and more than 64,000 written inquiries from doctors and their office assistants. The Status and UCR Unit made more than 3,500 changes in providers' computer records and handled 2,450 inquiries and requests for fee revisions.

HEALTHY FINANCIAL CONDITION

A major accomplishment of 1977 was ending the year in healthy financial condition. For the first time in three years, we ended a year with a modest reserve. At year-end our reserve fund for the protection of subscribers stood at \$4,700,000. One year earlier we had been in a \$3,100,000 deficit position.

The reserve fund amounts to only six or seven days of claims payments or only \$1.23 for each insured member but nevertheless is a step in the direction toward a sound financial footing for subscribers.

We attribute our healthier condition to several factors: a 2.5 percent drop in utilization of benefits by subscribers; cost containment activities of the Plan; premium rate increases averaging 10 percent for small group and direct payment subscribers granted by the State Department of Insurance effective October 1, 1977, and increased renewal rates for larger groups.

YEAR OF GROWTH

The year 1977 was also a year of growth for Blue Shield. Our subscription income was \$182,000,000, an 11.5 percent increase over 1976. Claims incurred totaled \$155,000,000, a 4.7 percent increase. Both figures were records for the Plan.

COST CONTAINMENT

Our utilization review department, which endeavors to recognize, prevent, and eliminate any abuse of Blue Shield benefits, remained our principal cost containment activity with documented savings of close to \$1 million during the year, including cumulative savings through changed patterns of billing by providers.

Activities of this important department included prepayment review analysis of physician payment profiles, hospital audits, coordination of information within the Plan, and a physicians' visitation program, which resulted in some monetary refunds as well as clarification of misunderstanding and possible overuses of benefits. In addition, the department continued its poster program in which some 6,000 posters, detailing cost containment activities in cartoon form, were sent to about 900 large groups for display.

SECOND OPINION PROGRAM

In March, we introduced our Elective Surgery Second Opinion Program (ESSOP) which by year-end had some 1,000,000 members from 16 large groups. Only 432 persons sought Blue Shield-paid consultations. Of this number, in 147 cases, or about one-third, the need for surgery at that time was not confirmed. We have stressed the fact that these preliminary results have little meaning since they cannot take into account later surgery or alternative methods of treatment. We believe that a study completed after three years of the program will tell the real story.

While ESSOP was regarded by some as a cost containment program, we think of it also as a quality of medical care program. The same thing is true of our new Medical Necessity program announced last fall. This is a national Blue Shield activity which eliminates routine payment for some 28 obsolete surgical and diagnostic procedures without adequate justification from the physician. While some in the health-care field view this as a cost containment activity, we see it rather as contributing to quality of medical care. In internal review we found little utilization of most of these procedures in any event.

Blue Shield will persist in its review of the expectations and needs of the public and the medical profession, and will endeavor to continue to serve subscribers well with the co-operation and help of New Jersey's physicians, especially the 8,894 participating physicians, who have joined us in the

effort to provide service benefits since the founding of the Plan in 1942.

Filed in accordance with the recommendation of the Reference Committee.

Comparative Balance Sheet • December 31, 1977

<i>Assets</i>	<i>1977</i>	<i>1976</i>
Cash	\$ —	\$ 332,000
Investments	39,093,000	21,673,000
Accounts Receivable		
Subscriber Premiums	5,961,000	5,525,000
National Account Program	8,547,000	8,674,000
Federal Employee Program	2,154,000	2,455,000
Other	2,200,000	684,000
Accrued Income on Investments	522,000	305,000
Total Assets	<u>\$58,477,000</u>	<u>\$39,648,000</u>
<i>Liabilities</i>		
Provision for Outstanding Claims	\$30,135,000	\$29,659,000
Excess of Outstanding Checks Over Balance in Bank Account	5,038,000	—
Unearned Subscription Income	8,297,000	6,501,000
Accounts Payable	3,027,000	1,892,000
Reserve for Group Contract Settlement	4,629,000	2,234,000
Deposits from Organizations	2,644,000	2,456,000
Total Liabilities	<u>\$53,770,000</u>	<u>\$42,742,000</u>
<i>Reserves for Protection of Subscribers</i>		
Total Reserves (Deficit)	<u>\$ 4,707,000</u>	<u>\$ (3,094,000)</u>
Total Liabilities and Reserves	<u>\$58,477,000</u>	<u>\$39,648,000</u>

Comparative Statement of Operations

	<i>1977</i>	<i>1976</i>
Earned Subscriptions	\$181,624,000	\$162,890,000
Less:		
Claims Incurred	\$154,769,000	\$147,767,000
Operating Expenses	20,548,000	19,224,000
	175,317,000	166,991,000
Net Underwriting Gain (Loss)	\$ 6,307,000	\$ (4,101,000)
Income from Investments	1,682,000	1,379,000
Operating Gain (Loss) for the Year	<u>\$ 7,989,000</u>	<u>\$ (2,722,000)</u>
		\$ (2,722,000)

Statement of Reserves for Protection of Subscribers

	<i>1977</i>	<i>1976</i>
Reserves at Beginning of Year	\$ (3,094,000)	\$ (1,187,000)
Operating Gain (Loss) for the Year	7,989,000	(2,722,000)
	<u>\$ 4,895,000</u>	<u>\$ (3,909,000)</u>
Reserve Adjustments:		
Non-Admitted Assets	\$ (98,000)	\$ 653,000
Unrealized Capital	(165,000)	177,000
Miscellaneous	75,000	(15,000)
	<u>(188,000)</u>	<u>815,000</u>
Reserves (Deficit) at End of Year	<u>\$ 4,707,000</u>	<u>\$ (3,094,000)</u>

Table I
All Underwritten Services and Plan Payments

Surgical	952,945	29.2	\$ 75,620,334	49.0	\$79.35
Medical*	1,900,793	58.2	46,558,160	30.2	24.49
Obstetrics	47,666	1.5	13,203,060	8.5	276.99
Consultation	151,346	4.6	4,184,830	2.7	27.65
Anesthesia	215,515	6.5	14,855,373	9.6	68.93
Total	3,268,265	100.0%	\$154,421,757	100.0%	\$47.25

*Includes Lab, X-ray, Physical Therapy, etc.
The incidence rate for 1977 is 486 cases per thousand persons enrolled.

Table 2
Community Rated Rider Services and Payments

Surgical	122,298	15.8	\$ 2,612,692	23.8	\$21.36
Medical	9,657	1.3	330,262	3.0	34.20
Diag. X-ray	248,035	32.1	4,538,856	41.4	18.30
X-ray Therapy	4,890	.6	240,510	2.2	49.18
Physical Therapy	13,899	1.8	196,621	1.8	14.15
Pathology	373,795	48.4	3,053,225	27.8	8.17
Total	772,574	100.0%	\$10,972,166	100.0%	\$14.20

Table III
Distribution of Earned Subscription Income

Earned Subscription Income	\$181,624,000	100.0%
Incurred Claims	154,769,000	85.2
Surgical		41.8
Medical		25.7
Obstetrical		7.2
Consultation		2.3
Anesthesia		8.2
Operating Expense	20,548,000	11.3
Underwriting Gain	6,307,000	3.5

N.J. Participating and Non-Participating Physicians By County

Basic

County	Total Elig. Phys.	Participating					Non-Participating					% P.P. as of 12-31-77
		Total	M.D.	D.O.	D.P.M.	Lab.	Total	M.D.	D.O.	D.P.M.	Lab.	
ATLANTIC	288	277	230	25	19	3	11	11				96.2
BERGEN	1509	833	717	64	40	12	676	647	14	11	4	55.2
BURLINGTON	372	347	269	60	16	2	25	20	4	1		93.3
CAMDEN	802	734	470	209	49	6	68	59	5	3	1	91.5
CAPE MAY	83	80	57	17	4	2	3	3				96.4
CUMBERLAND	163	157	138	9	7	3	6	6				96.3
ESSEX	1701	1345	1235	37	64	9	356	346	5	1	4	79.1
GLOUCESTER	186	163	110	36	13	4	23	19	4			87.6
HUDSON	868	733	673	21	29	10	135	128	2	3	2	84.4
HUNTERDON	74	69	68	1			5	5				93.2
MERCER	616	491	454	14	20	3	125	122	3			79.7
MIDDLESEX	705	530	488	18	18	6	175	163	2	4	6	75.2
MONMOUTH	686	532	489	22	18	3	154	146	3	5		77.6
MORRIS	602	495	442	30	18	5	107	103	3	1		82.2
OCEAN	317	208	175	23	9	1	109	100	6	2	1	65.6
PASSAIC	674	521	467	27	22	5	153	145	3	3	2	77.3
SALEM	59	57	44	11	1	1	2	2				96.6
SOMERSET	243	203	188	8	4	3	40	38	1	1		83.5
SUSSEX	96	91	81	6	3	1	5	5				94.8
UNION	884	646	547	55	36	8	238	234	1	1	2	73.1
WARREN	89	84	75	7		2	5	5				94.4
OUT OF STATE	313	298	242	47	9		15	13	1		1	95.2
TOTAL	11330	8894	7659	747	399	89	2436	2320	57	36	23	78.5

N.J. Participating and Non-Participating Physicians By County

Usual, Customary or Reasonable Fee

County	Total Elig. Phys.	Participating					Non-Participating					% P.P. as of 12-31-77
		Total	M.D.	D.O.	D.P.M.	Lab.	Total	M.D.	D.O.	D.P.M.	Lab.	
ATLANTIC	288	253	212	22	17	2	35	29	3	2	1	87.8
BERGEN	1509	689	604	48	29	8	820	760	30	22	8	45.7
BURLINGTON	372	315	243	56	14	2	57	46	8	3		84.7
CAMDEN	802	672	427	194	45	6	130	102	20	7	1	83.8
CAPE MAY	83	65	46	14	4	1	18	14	3		1	78.3
CUMBERLAND	163	147	129	9	6	3	16	15		1		90.2
ESSEX	1701	1160	1068	31	52	9	541	513	11	13	4	68.2
GLOUCESTER	186	151	100	35	13	3	35	29	5		1	81.2
HUDSON	868	648	598	18	25	7	220	203	5	7	5	74.7
HUNTERDON	74	64	63	1			10	10				86.5
MERCER	616	437	403	12	19	3	179	173	5	1		70.9

MIDDLESEX	705	465	423	17	19	6	240	228	3	3	6	66.0
MONMOUTH	686	435	402	17	15	1	251	233	8	8	2	63.4
MORRIS	602	423	373	27	18	5	179	172	6	1		70.3
OCEAN	317	166	139	19	8		151	136	10	3	2	52.4
PASSAIC	674	459	414	25	18	2	215	198	5	7	5	68.1
SALEM	59	55	43	10	1	1	4	3	1			93.2
SOMERSET	243	177	164	8	3	2	66	62	1	2	1	72.8
SUSSEX	96	81	74	5	2		15	12	1	1	1	84.4
UNION	884	556	473	49	28	6	328	308	7	9	4	62.9
WARREN	89	81	72	7		2	8	8				91.0
OUT OF STATE	313	201	161	31	9		112	94	17		1	64.2
TOTAL	11330	7700	6631	655	345	69	3630	3348	149	90	43	68.0

N.J. Participating and Non-Participating Physicians By Specialty

Basic

Specialty	Total Elig. Phys.	Participating					Non-Participating					% P.P. as of 12-31-77
		Total	M.D.	D.O.	D.P.M.	Lab.	Total	M.D.	D.O.	D.P.M.	Lab.	
ANES.	542	343	322	21			199	197	2			63.3
DERM. SYPH.	201	132	128	4			69	69				65.7
INT. MED.	1994	1494	1431	63			500	497	3			74.9
NEUR. SURG.	89	69	68	1			20	20				77.5
OBST. GYN.	867	710	684	26			157	156	1			81.9
OPHTH.	394	249	245	4			145	145				63.2
ORTH. SURG.	405	272	264	8			133	132	1			67.2
OTOL.	236	158	151	7			78	76	2			66.9
PATH.	179	149	144	5			30	29	1			83.2
PED.	786	683	676	7			103	103				86.9
PHYS. MED.	45	32	28	4			13	13				71.1
PLAST. SURG.	82	38	38				44	44				46.3
ANALY. LABS.	112	89				89	23				23	79.5
PROCT.	35	18	11	7			17	17				51.4
PSY. & NEURO.	769	543	526	17			226	226				70.6
RADIOLOGY	394	316	294	22			78	78				80.2
SURG.	1001	803	770	33			198	198				80.2
THOR. SURG.	86	70	69	1			16	16				81.4
UROL.	237	157	153	4			80	80				66.2
PODIATRY	435	399			399		36			36		91.7
GENERAL	2441	2170	1657	513			271	224	47			88.9
TOTAL	11330	8894	7659	747	399	89	2436	2320	57	36	23	78.5

N.J. Participating and Non-Participating Physicians By Specialty

Usual, Customary or Reasonable Fee

Specialty	Total Elig. Phys.	Participating					Non-Participating					% P.P. as of 12-31-77
		Total	M.D.	D.O.	D.P.M.	Lab.	Total	M.D.	D.O.	D.P.M.	Lab.	
ANES.	542	338	319	19			204	200	4			62.4
DERM. SYPH.	201	108	104	4			93	93				53.7
INT. MED.	1994	1357	1300	57			637	628	9			68.1
NEUR. SURG.	89	42	41	1			47	47				47.2
OBST. GYN.	867	627	602	25			240	238	2			72.3
OPHTH.	394	232	230	2			162	160	2			58.9
ORTH. SURG.	405	212	204	8			193	192	1			52.3
OTOL.	236	134	126	8			102	101	1			56.8
PATH.	179	110	108	2			69	65	4			61.5
PED.	786	584	577	7			202	202				74.3
PHYS. MED.	45	24	21	3			21	20	1			53.3
PLAST. SURG.	82	31	31				51	51				37.8
ANALY. LABS.	112	69				69	43				43	61.6
PROCT.	35	19	13	6			16	15	1			54.3
PSY. & NEURO.	769	493	476	17			276	276				64.1
RADIOLOGY	394	278	257	21			116	115	1			70.6
SURG.	1001	699	667	32			302	301	1			69.8
THOR. SURG.	86	63	62	1			23	23				73.3
UROL.	237	150	146	4			87	87				63.3
PODIATRY	435	345			345		90			90		79.3
GENERAL	2441	1785	1347	438			656	534	122			73.1
TOTAL	11330	7700	6631	655	345	69	3630	3348	149	90	43	68.0

OFFICERS

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John S. Robinson, Executive Vice-President and Secretary-Treasurer

Jean R. Geiger
Vice-President —
Communications

Francis J. Novak, Vice-President — Operations
W. John Gould, Vice-President — Corporate
Planning and Finance

Charles L. Cunniff, M.D.
Vice President — Medical Affairs
and Medical Director

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Charles O. Tyler, M.D. (1980)

Robert E. Verdon, M.D. (1978)

TRUSTEES EMERITUS

	<i>Appointed</i>	<i>Term as Board Member</i>
Joseph I. Echikson, M.D.	1970	1954-1970
Elton W. Lance, M.D.	1971	1962-1971
John S. Thompson	1966	1942-1965
Thomas J. White, M.D.	1973	1951-1973
Joseph M. Keating, M.D.	1975	1953-1975

ADVISORS TO THE BOARD OF TRUSTEES

	<i>Appointed</i>	<i>Term as Board Member</i>
Andrew P. Dedick, Jr., M.D. Consultant to Chairman of the Board	1973	1961-1973
Irving P. Borsher, M.D.	1965	1950-1965

*Resigned

**Deceased

Medical Defense and Insurance

Paul J. Kreutz, M.D., Chairman, Elizabeth

(Reference Committee "C")

In 1977, the major changes affecting our plans were as follows:

1. Since the last Annual Report, E. & W. Blanksteen has advised that the limits of the Professional Overhead Expense Plan have been doubled from \$2500 monthly benefit to \$5000 monthly benefit. The National Casualty Company also has filed for a reduction of rates and they will be effective as soon as they are approved by the New Jersey State Department of Insurance.

2. Our Major Expense program was transferred from the National Casualty Company to the Nationwide Life Insurance Company on a guaranteed issue roll-over basis as of March 1, 1978.

ACCIDENT AND HEALTH INSURANCE

The Society's Accident and Health Insurance programs are administered by the E. & W. Blanksteen Agency, Inc., who just have completed their 47th year of service to our members. This comprehensive disability income program now affords a monthly benefit up to \$4600 a month during total disability due to injury or sickness. The program consists of two parts: The Basic-Extended plan and the Long Term plan. The plans differ primarily in the length of time benefits are payable. For an accident disability, the Basic plan pays up to five years, the Basic-Extended plan up to lifetime, and the Long Term plan up to lifetime. For a sickness disability, the Basic plan pays up to two years, the Basic-Extended plan up to seven years, and the Long Term plan up to age 65 and beyond. Both the Basic-Extended plan and the Long Term plan are underwritten by the Nationwide Mutual Insurance Company. Members may carry up to \$4600 of which up to \$2000 may be in the Basic plan and up to \$3600 a month in the Long Term plan. Up to three policies are issuable to any member for maximum flexibility. The Company will rearrange policies and existing coverage to accommodate changing needs within the three-policy limit.

BASIC-EXTENDED PLAN

The Basic Disability plan provides as much as \$2000 monthly benefit. Benefits are payable from the first day of accident total disability for as long as five years and the eighth day of sickness total disability for as long as two years. Waiting periods of 30 or 60 days are available to provide reduced premiums for those whose circumstances make desirable a plan where benefits could begin on a later date than first day of accident and eighth day of sickness. The plan also pays, at half the monthly rate, accident partial disability benefits for as long as six months. Also included in the plan are accidental death and dismemberment benefits. By adding the Extended plan, accident total disability benefits may be extended to lifetime and sickness benefits extended for an additional five years, for a total of seven years. There are 4226 basic policies covering our members with some members having two basic policies. It is the Administrator's practice to combine two basic policies into one whenever members revise or increase their insurance programs so as to simplify their record-keeping.

LONG TERM PROFESSIONAL INCOME PROTECTION PLAN

Members now may carry up to \$3600 under this plan. Benefits are payable for lifetime for accident total disability and to age 65 and beyond for sickness total disability. One of the chief purposes of this plan is to provide both accident and sickness disability benefits to the age where other financial arrangements begin to fall into place; such as annuities, life insurance settlement options, and Social Security. The plan also affords six months of accident partial disability benefits at half the monthly benefit rate. Benefits may begin from the first day of accident, eighth day of sickness, or first day of hospitalization—or from the 31st, 61st, 91st or 181st day of disability, with appropriate reductions in premium. Currently 1309 members participate in this program which began in 1965.

It is possible for a member to have the various disability plans in almost any combination of monthly benefit and plan to fit personal requirements. The ideal goal for most doctors is to insure about two-thirds of monthly gross income. More monthly benefit than this is unnecessary inasmuch as all benefits are tax free for Federal Income Tax purposes. Members who apply for the Basic plan within their new-member periods are issued coverage, within certain limits, without regard to medical history.

All of our accident and health policies have the guaranteed Conversion Provision Rider. Briefly, this rider provides that if Nationwide were unilaterally to terminate any of its accident and health insurance programs for members of the Society, the Company is committed to issue a guaranteed renewable policy for the same benefits as are provided for in doctor's original policy.

MAJOR EXPENSE PLAN

The Society's Major Expense plan was transferred to the Nationwide Life Insurance Company and a new, improved program put into effect, making professional-fee coverage available for the first time under this program as an option to policyholders under Medicare age.

This program is designed especially to work in conjunction with any Blue Cross and/or Blue Shield contract you may carry. The combination of the new \$200 deductible Quarter Million Dollar Major Expense Plan and some basic hospital coverage can provide excellent protection for you.

The coverage consists of two parts:

1. **Basic Coverage**—The \$15,000 basic coverage is subject to a \$200 deductible and is paid *regardless of any other insurance or service plan you may have*. Basic coverage provides 100 percent of \$40 per day toward hospital room and board in addition to any Blue Cross or Basic hospital coverage, \$32 a shift for nursing (RN or LPN in hospital; RN out of hospital) and the scheduled amounts of the optional professional fee coverage.

In addition, it provides 80 percent of various services and supplies when out of the hospital. It may include professional fee coverage on an optional basis as described in the folder. All professional fee payments are, as is all basic coverage, paid in addition to other payments—in particular, Blue Shield.

2. **Quarter Million Umbrella Coverage**—This coverage is designed to take over where Blue Cross leaves off and becomes operative when \$15,000 of umbrella-covered expense has been incurred. Umbrella-covered expense consists of 100 percent of full semi-private hospital care including miscellaneous hospital expense, full nursing charges and 80 percent of certain services and supplies out of the hospital. Payments are made under the Quarter Million Dollar Umbrella coverage to the extent that they have not been paid by other policies, including this one. *But*—the Basic \$40 daily hospital benefit *and* the full semi-private benefit under the Umbrella can be payable simultaneously. This makes certain that payment will be made in the event the insured is confined to a private room in the hospital. Thus, participants are assured of virtually complete hospital and nurse coverage even after Blue Cross Benefits have ended.

Unmarried, dependent children are covered to age 25. All members who are under age 70 and their spouses under age 70 are eligible to apply. At eligibility for Medicare, coverage for such person automatically becomes modified Basic Coverage with a \$7500 maximum for each Covered Person, with a deductible of \$750 or the amount of Covered Expense payable by Medicare, whichever is greater. Medicare Covered Expense includes hospital miscellaneous services. There is no Quarter Million Coverage or Optional Professional Fee Coverage for those eligible for Medicare. Full coverage continues for those not eligible for Medicare. The program is administered by E. & W. Blanksteen.

HOSPITAL-MONEY PLAN

Our Hospital-Money policy, administered by E. & W. Blanksteen Agency, Inc., provides \$20, \$30, \$40, \$50 or \$60 a day for each day of hospital confinement up to a maximum of 365 days for any one confinement. It can cover member, spouse and dependent children. New members are able to obtain the \$20 a day program non-selectively as part of their new-member privilege. Benefits under this plan are paid regardless of other insurance and are used to supplement the benefits provided by Blue Cross, Major Expense and Major Medical plans. It is particularly useful to provide money for private-room coverage where adequate provision is not made by underlying plans. There are 271 members participating in this program.

OVERHEAD EXPENSE PROGRAM

Many of our members find that their overhead expenses have become quite high, with employees' salaries, rentals, and other fixed expenses pertaining to their practice. Our Professional Overhead Expense Program is underwritten by the National Casualty Company and administered by the E. & W. Blanksteen Agency, Inc. It now provides up to \$5,000 monthly benefit beginning with the 31st day of total disability and lasting as long as two full years. Currently, 379 members are covered under the plan. In accordance with IRS regulations, the premiums under this program are considered business expense *and are tax deductible*.

LIFE INSURANCE—NATIONWIDE LIFE INSURANCE COMPANY AND BANKERS LIFE COMPANY OF DES MOINES, IOWA

The maximum coverage under our Life Plan is \$250,000 with the \$100,000 maximum coverage Bankers Life Plan

available in addition to the \$150,000 program of the Nationwide Life Insurance Company that has been in effect for many years. Our original Nationwide Life Insurance program includes not only the member but also his spouse and dependent children (between the ages of 15 and 21; up to age 26 if a college student), as well as employees. An important feature of this expansion is that each person will have his own Five-Year Renewable and Convertible Term Policy and it is not necessary for the member to take out insurance for himself in order to provide coverage for a member of his family or an employee. This added feature enables the life insurance program to serve many more needs of our members, especially those who wish to provide benefit programs for their employees. The administrators are E. & W. Blanksteen Agency, Inc.

The Nationwide life program provides each insured person with a Five-Year Renewable and Convertible Term policy with a guaranteed conversion on a non-medical basis to permanent life insurance at any time. The program now provides up to \$150,000 of coverage for members and up to \$50,000 of coverage for spouse, dependent children, and employees. All coverage is issued in the form of convenient units of \$10,000 with Waiver of Premium and Double Indemnity for accidental death included without premium charge. Since inception of the program, there have been 353 death claims, resulting in a total payout of \$3,826,900.

As a result of the large volume of insurance and strong participation of our members in this program we are able to have non-cancellable term life insurance at a very low cost. At the present time, over 1,800 of our members participate in the program with approximately \$31,000,000 of insurance currently in force. This plan also is available to spouses, children, and employees and 119 of them participate in this program.

The additional \$100,000 coverage through the Bankers Life Company is available to members whether or not they carry insurance under the original program. This will make possible larger amounts of insurance without the necessity of another physical examination and gives our members even greater flexibility in establishing their insurance program. The net cost and structure of the Bankers Life Program is quite similar to that of the Nationwide Life Insurance Company described above.

Of our members 197 have applied for and were issued \$7,755,000 of insurance protection under this new plan.

SIX POINT, HIGH-LIMIT ACCIDENT INSURANCE PLAN

Our Six Point, High-Limit Accident Insurance Plan with the Nationwide Mutual Insurance Company, administered by E. & W. Blanksteen Agency, Inc., provides up to \$200,000 for accidental death benefit with dismemberment benefit, loss of sight, exposure, disappearance, and even a total disability feature at less than the usual cost of the accidental death benefit alone.

Coverage is issued under this program to members under the age of 70 in the active practice of medicine, without regard to medical history. We have a special Six Point, High-Limit Accident Insurance program enrollment at the beginning of each year.

Special spouse coverage is available under this policy at very low cost. Seven hundred twenty of our members participate in this program.

PROFESSIONAL CORPORATIONS

E. & W. Blanksteen Agency, Inc., our administrator for the Basic-Extended, Long Term Professional Income Protection Plan, Major Expense Plan, Hospital-Money Plan, Six Point High-Limit Accident Insurance Plan, Overhead Expense Plan, and Life Insurance Plan, has advised that all the programs are adaptable for use in professional corporations with necessary assignment forms available upon request.

RECOMMENDATION

That the E. & W. Blanksteen Agency, Inc., be continued as the Official Broker for MSNJ's Accident and Health Insurance, Major Expense Insurance, Hospital-Money Plan, Life Insurance, Six Point High-Limit Accident Insurance, and Professional Overhead Expense Plan.

Approved in accordance with the recommendation of the Reference Committee.

PROFESSIONAL LIABILITY

The details of the Medical Inter-Insurance Exchange and the New Jersey State Medical Underwriters Program will be encompassed in the New Jersey State Medical Underwriters' report. Suffice it to say that rates will remain the same for policy year 1978.

The New Jersey State Medical Underwriters has undertaken, with the cooperation and approval of this Committee, some innovative claims' handling and loss control concepts which should prove beneficial to all insured physicians under these programs.

The Federal Insurance Company under the State Government Reinsurance Program has filed for a 41 percent increase which has been pending before the Insurance Department since September of 1977. The Commissioner has not acted upon it yet.

The Garramone legislation failed to achieve passage during 1977. The Officers and Staff of your Society are working busily toward the introduction of legislation that will cover such areas as the statute of limitations, collateral sources of income, informed consent, *res ipsa loquitur*, periodic payments, and immunity for peer review activity. Our objective is to secure a single bill to be introduced as an administration-sponsored effort. Meetings are being held with representatives of the Governor to prepare the necessary drafts.

STATEWIDE BLUE CROSS/BLUE SHIELD PROGRAM BLUE CROSS/BLUE SHIELD GROUP MAJOR MEDICAL PROGRAM

Participation in the Society's *Statewide Blue Cross-Blue Shield Program* is continuing to increase. Currently, there are more than 5,000 doctors and employees in 17 counties enrolled in the Program. (Doctors may use the Program as a fringe benefit and enroll their full-time employees.) This is a jump of several hundred per cent in the number of participants since the Program's beginning in 1972.

A factor behind the increase in participation is the service provided by the Program's designer and administrator, Donald F. Smith and Associates. With personnel assigned solely to our account, Smith and Associates now handles virtually all aspects of the Program, from enrollments to billing and everything in between. This makes it easy for

member physicians to channel all matters involving the Blues through the administrator and avoid direct dealings with the Blues. The administrator, by representing a group of our size, can deal with the Blues through an account service representative. This advantage is not available to physicians contacting the Blues on an individual basis, and they may end up explaining their problem or need to a different person each time they call. Dealing, instead, with the administrator has proved to be a significantly more efficient procedure for settling claims problems and getting quick and accurate answers to inquiries.

In 1977, a Blue Cross-Blue Shield *Group Major Medical Program* was designed and implemented for our members by Smith and Associates. The Program is now just over a year old and already covers more than 2,000 physicians and employees.

The design of the programs is such that together they form a solid block of health insurance protection. The Blue Cross-Blue Shield Program provides the following *standard benefits*...

- Blue Cross 120-Day Comprehensive Coverage
- Blue Shield Schedules; a choice of the 500 or 750 Series or the Prevailing Fee (UCR) Schedule

... together with these *additional benefits*:

- Unmarried children are covered until the end of the year in which they reach age 23, as opposed to age 19.
- Coverage under the Program may be continued by the surviving spouse and dependent children of a deceased member.
- The full semi-private rate, rather than the \$30 per day payment is paid in non-member hospitals outside of New Jersey.
- The program provides 120 days semi-private care *per admission*, instead of per benefit year.
- There is 120 days coverage for mental conditions, tuberculosis, alcoholism, polio and contagious diseases, instead of the standard 20 days.

Under the Major Medical Program...

- Benefits are payable when covered expenses exceed the benefits under the Blue Cross-Blue Shield Program plus a cash deductible of \$100. It is not necessary to satisfy a new cash deductible for each separate accident or illness, and there is a maximum of two deductibles per family per calendar year.
- Except for the \$1,000 limit per calendar year for out-of-hospital treatment of mental conditions, maximum payment under the Major Medical Program is \$50,000 per person per calendar year *for an unlimited number of years*.
- The full semi-private hospital room and board rate is a covered expense, and there is an additional allowance for a private room.
- Physicians' and surgeons' charges are covered expenses.

RECOMMENDATION

That Donald F. Smith and Associates be continued as MSNJ's Official Broker for its Blue Cross-Blue Shield Program and its Blue Cross-Blue Shield Group Major Medical Program.

Approved in accordance with the recommendation of the Reference Committee, and the report as a whole was filed.

Retirement Plan for Physicians

Nicholas E. Marchione, M.D., Chairman, Vineland

(Reference Committee "C")

HR-10 (KEOGH) VARIABLE ANNUITY RETIREMENT INVESTMENT PLAN

Our Keogh Plan provides tax-deductible contributions up to the lesser of \$7500 or 15 percent of earned income. In addition, voluntary contributions of up to the lesser of \$2500 or 10 percent of earned income may be made, to take advantage of the tax-free compounding and favorable final-funding guarantees.

This plan, established in 1970, is administered by E. & W. Blanksteen Agency, Inc., and underwritten by The Prudential Insurance Company of America.

The program includes five unique advantages, in addition to the well-known tax-saving and tax-shelter features of the Keogh Law:

1. A lifetime monthly variable payout, based on a common-stock portfolio. (The Variable Annuity)
2. A lifetime monthly fixed-dollar annuity.
3. Contributions even beyond age 70½, as long as you are self-employed.
4. A death benefit guarantee, so that, if the participant dies during the accumulation period, his beneficiary never will receive less than the amount the participant has paid in.
5. Flexibility during accumulation years, permitting the allocation and transfer of funds, at the participant's option, to and from the common-stock and the fixed-dollar account.

The plan not only provides an excellent means of accumulating funds, but has a splendid final funding mechanism consisting of a Group Variable or a Group Fixed-Dollar Annuity, combined with tax-free government bond distributions. Many members who accumulate their funds elsewhere find it beneficial to transfer to this program at age 70½ and to take advantage of the final funding arrangement.

Throughout the state, we have 195 plans in effect, covering 226 people (since a partnership has one plan for all its partners, a retirement plan covering a partnership may have more than one physician-participant) with total deposits of \$2,156,098.22 since the plan's inception.

The Society has recognized that some of its members may see fit to practice in the form of a corporation. Therefore, the Committee recommended, and the Society approved in 1970, the establishment of The Medical Society of New Jersey Retirement Plan Trust-B, which adopted a Corporate Master Retirement Plan, using the same funding agents as the Keogh program just described. This program, in the form of a Master Profit-Sharing Plan, permits corporations, one of whose employees is a member of the Society, to place up to 15 percent of payroll in a tax-sheltered program with the same flexibility and options as our Keogh program, using the Prudential Insurance Company's group Fixed-Dollar Annuity and group Variable Annuity.

This plan, which should provide a substantial savings, since it is not necessary to have a plan and trust specially drawn for you, is administered by E. & W. Blanksteen Agency, Inc., who will be pleased to furnish members with full information concerning the plan. Many large corporations and other organizations use these same funding agents for their tax-deferred retirement plan, including that of our administrator.

PRO SERVICES, INC.

The Medical Society authorizes the following Internal Revenue Service (IRS) qualified prototype retirement plans for use by members and their employees.

	<i>IRS Approval Number</i>
Self Employed — Keogh	
Profit Sharing	H7730910
Money Purchase	H7730920
Individual Retirement Account — IRA	I7607610
Professional Corp.	
Profit Sharing	C7717140
Money Purchase	C7717150
Fixed Benefit	(Number not assigned)

These plans are made available on a purely optional basis as a service to members by the Society. No minimum participation is required. Members are free to use any plan for which they are eligible and which meets their specific needs.

The authorized service and sales representative for these retirement plans is PRO Services, Inc. (PRO). The firm was originally appointed in this capacity in 1970.

CURRENT STATUS

According to a report supplied by the plan trustee, Bradford Trust Company of New York City, there were, as of February 16, 1978, 770 participants under the Society Keogh plan and a total of \$4,543,123 of mutual fund assets. PRO estimates another \$325,000 of investment assets held by the trustee for professional corporation plans.

In addition, PRO indicates that more than \$3 million of life insurance protection currently is in force on the lives of participants and nearly \$1 million of cash values are contained in annuity and insurance contracts combined.

AUTHORIZED AGENT

PRO Services, Inc., with headquarters in Flourtown, Pennsylvania, serves as the authorized agent for more than 50 medical societies and bar associations, mostly in the northeast and in Florida.

PRO maintains 29 qualified field representatives, of which ten are responsible for various assigned areas in New Jersey. It is anticipated that additional representatives will be added in the future.

In addition to field representatives, PRO maintains a fully staffed service department for clients in its home office. This service staff is supervised by a full-time, in-house attorney, a senior department manager, and five, fully trained employees. This extensive service department is deemed necessary to assist participants with all of the new government compliance reports and regulations mandated by the new ERISA laws.

Below is a brief outline of the PRO Plan features.

FEATURES OF THE MEDICAL SOCIETY OF NEW JERSEY PLANS

Corporate Trustee—Under ERISA, individuals are well advised not to act as their own plan trustees. This added responsibility and liability is not worth any small savings

which might be involved. The Corporate Trustee should agree to maintain all account records and to provide each participant with all the necessary individual reports and tax forms. The maintenance of certain plan records for a period of six years is an important new provision of the ERISA law and must be observed strictly.

The MSNJ retirement plans have a corporate trustee—Bradford Trust Company of New York.

Segregated Investment Accounts—To avoid fiduciary responsibility and liability as an investment adviser, a plan should provide that each employee be given the absolute authority to select his or her own investments which are best suited to individual needs. Pooled accounts or arrangements by which the employer chooses investments for all participants should be avoided.

If the plan provides for individual accounts and a plan participant or beneficiary is permitted to, and in fact does, exercise independent control over the assets in his or her own account (i.e., he or she makes investment decisions), a fiduciary is not liable for losses attributed to such control. In order for there to be independent control, Congressional Committee reports indicate a broad range of investments must be available to the participant.

The MSNJ retirement plans provide for segregated accounts—Each employer and employee chooses his own investments and has the right, individually, to make changes at any time.

Investment Alternatives—For the employer to avoid the possibility of being considered an investment adviser, the plan he chooses should provide for a broad range of investment possibilities. A plan which is limited to a particular group of mutual funds by one sponsor or common trust funds of one bank might be considered restrictive. A plan which provides a broad range of investments, including stocks, bonds, any mutual fund, savings instruments, and insurance contracts would avoid any later criticism of restricted investment opportunities. The plan should provide unlimited transfers and changes in investment instructions so that each individual better could meet his changing needs.

ERISA makes clear that a fiduciary (employer in most cases) must diversify plan investment alternatives to minimize the risks of large losses. The fiduciary should not limit the whole or an unduly large portion of the plan assets to one type of investment alternative.

The MSNJ retirement plans permit wide investment alternatives—Each participant may choose his preferred investment alternative—any marketable stocks, bonds, mutual funds, savings instruments, bank pooled trusts, and annuity or insurance contracts.

Service—The availability of professional advice in the retirement planning field always has been an important aspect of any good tax qualified retirement plan. With ERISA and the changes brought about by the Tax Reform Act of 1976, this has become even more important. You should determine if your plan sponsor has the necessary facilities and personnel to service your questions and problems and to assist you in coordinating your retirement program with your overall financial planning requirements. Annual tax deductible contributions to retirement plans can represent a large portion of retirement income for most individuals. Ordinarily, a Keogh plan permits up to \$7,500 per year of contribution (up to \$10,000 if you have a covered employee). Corporate pension and profit sharing may allow \$25,000 per year and, in some cases, even more. These large numbers mandate that a good retirement plan be examined

carefully and integrated with your other investment and insurance programs. The law requires that employees be advised at least annually regarding their program. In addition to providing written reports, a plan sponsor which is available to make at least annual person-to-person service calls by qualified representatives is a desirable feature.

The MSNJ retirement plans provide full service—PRO Services, Inc., the sales and service agent for the MSNJ plans, offers an annual plan review without cost or obligation to each participant and provides a fully staffed service department to answer plan questions and provide assistance with ERISA compliance.

Plan Administration—In the absence of a written agreement appointing another person or entity as your plan administrator, you are considered, under law, to be your own plan administrator and liable as a fiduciary for the accuracy and timeliness of all reports to the government and to employees. Many employers are under the erroneous impression that their trustee or accountant performs this function. We know of no case where this is true. Trustees and accountants may, in some cases, supply some of the information required for government reports, but they do not permit themselves to be named in your plan or in a separate agreement as your plan administrator. A plan which offers you the opportunity to designate a qualified plan administrator is an important and advantageous arrangement for you.

The MSNJ retirement plans provide an optional ERISA service—For a low annual fee, PRO Administrators, Inc., a subsidiary of PRO Services, Inc., will be the named administrator of any MSNJ plan and take full responsibility for all government filings and reports to plan participants.

Costs—Though this should be the least important consideration, cost should be reasonable for the services performed. It is sometimes difficult to make an accurate comparison since plans make charges in different ways. There are usually custody fees, annual trustee fees and transaction fees. A plan which provides a fixed-dollar annual trustee fee is usually more economical than one which charges a percentage fee based on assets and/or earnings of the trust. In the latter case, as assets grow, fees become higher each year and, therefore, the trustee fee is open-ended. A reasonable flat fixed annual fee is preferable.

The MSNJ retirement plans feature low administrative costs—Although fully trusted and offering a broad range of services with maximum flexibility, the cost of these plans to participants is reasonable and is a "flat" fee, based on participants and not on total assets.

Life insurance benefit—Many participants find that the inclusion of life insurance as a part of their retirement plan assets holds advantages for them. Premiums paid as part of qualified plans are largely tax deductible, death proceeds can avoid both income tax and estate tax to the beneficiary and, at retirement, all or a portion of other plan assets can be transferred to the insurance contract to purchase a lifetime income at rates guaranteed in the contract at the date of purchase.

The MSNJ retirement plans provide life insurance regardless of health—A participant may elect any life insurance contract with any company of his choice. However, Philadelphia Life Insurance Company, through PRO, will issue up to \$37,500 of death protection at standard rates (to age 50 and \$30,000 to age 55) to any MSNJ member (\$20,000 to any employee to age 50) without evidence of insurability and regardless of condition of health. This is a valuable benefit

for any member who might otherwise be rated (pay higher premiums) or be totally uninsurable.

Filed in accordance with the recommendation of the Reference Committee.

Resolutions

#4
Professional Liability Insurance Coverage

From the Hudson County Medical Society

(Reference Committee "C")

Whereas, our current medical liability insurance policies, be they with the Medical Inter-Insurance Exchange of New Jersey or the State Reinsurance Facility, cover us for our actions as members of committees of a hospital medical staff, but do not cover us in the defense of actions brought against officers and/or department heads acting in an administrative capacity; and

Whereas, recently there was a suit brought against a local hospital, the president of the staff, and the director of medicine, which was settled by the hospital's insurance carrier, but failed to relieve the defendant physicians of liability of the charge of being negligent in carrying out their administrative responsibilities; and

Whereas, the insurance company of the New Jersey Hospital Association has stated in writing that they would only cover

said physicians in excess of the amount of their personal medical liability insurance; now therefore be it

RESOLVED, that the Medical Society of New Jersey investigate the problem caused by this inequity and, if possible, resolve it with the respective insurance companies to the satisfaction of all concerned.

Reference Committee recommended that the above "RESOLVED" be amended by substitution of the following:

RESOLVED that the Medical Society of New Jersey involve itself in the problem caused by inadequate insurance coverage for physicians who are acting in an administrative capacity in their hospitals, and resolve the inequity with the involved hospital insurance companies and medical liability carriers.

Adopted as amended by the Reference Committee.

#5
Reduce Liability Premiums for New Solo Practitioners

From Essex County Medical Society

(Reference Committee "C")

Whereas, the cost of establishing a new medical practice entails a large financial outlay; and

Whereas, all physicians in the Medical Inter-Insurance Exchange of New Jersey must pay the surplus as well as the professional liability premiums; and

Whereas, the captive carrier in the State of New York has made provision to assist young physicians by offering a reduced premium in their first year of solo practice; now therefore be it

RESOLVED, that the Medical Society of New Jersey petition the Medical Inter-Insurance Exchange of New Jersey to reduce by half the first year of professional liability premium

on all new physicians starting their first solo practice.

Rejected

Reference Committee recommended that the last "RESOLVED" be amended to read as follows:

RESOLVED that the Medical Society of New Jersey petition the Medical Inter-Insurance Exchange of New Jersey to reduce by half the first year of professional liability premium for physicians who are entering the practice of medicine for the first time and in solo practice.

Motion from the floor of the House to delete the last four words and place a period after the word "time" was defeated.

Resolution #5, including the amended "Resolved," was rejected by the House.

REFERENCE COMMITTEE "D"

Daniel J. O'Regan, M.D., Hudson
Chairman

James A. Rogers, M.D., Passaic

Ralph Cavalier, M.D., Atlantic

Frank A. Wolf, M.D., Warren

Victor H. Boogdanian, M.D., Middlesex

Robert H. Stackpole, M.D., Union

Alternate Member

Reports:

Board of Trustees' Items

Committee on Medical Education

**Committee on Emergency Medical
Care**

**Committee on Medicine and
Religion**

Resolutions #6, #20

Board of Trustees' Items

COUNCIL OF STATE COMMITTEES ON CME (Reference Committee "D")

The Board voted to join and financially to support the Council of State Committees on Continuing Medical Education, whose purpose is to promote communication between the states, to relate CME at the state level to the needs of the physician, to maintain the function of the state medical societies as survey and accrediting bodies for groups offering CME within the state, and to participate with such organizations as may be deemed appropriate in the formation of policies concerning CME.

Filed in accordance with the recommendation of the Reference Committee.

PRACTICE RELATED EDUCATIONAL PROGRAM (PREP)

(Reference Committee "D")

The Board voted to endorse PREP for use by members of the Medical Society of New Jersey.

PREP is a new system in continuing medical education, developed by the College of Physicians of Philadelphia in cooperation with the National Board of Medical Examiners, based on the premise that the busy physician requires a program that specifically will address itself to his or her practice. It is approved for Category I credit in the AMA Physician's Recognition Award.

Filed in accordance with the recommendation of the Reference Committee.

Medical Education

Arthur Bernstein, M.D., Chairman, Maplewood

(Reference Committee "D")

The Committee on Medical Education devoted most of its energy during the past year to three major projects. The first was to make sure that all the members of the state Medical Society complied with the 150 hours of continuing medical education credits required for continuing membership in the Society as ordered by the House of Delegates. To insure maximal compliance, the Committee sent lists of members who had failed to comply with the mandate to the twenty-one county medical societies to get grass roots involvement in meeting this generally accepted standard. We wish to thank the county medical societies for their cooperation and their help in bringing in many of our "reluctant dragons." At this time there are 582 delinquent physicians who have failed to meet these minimal requirements. The problem will need discussion in the House of Delegates.

To make it easier for physicians to complete their 150 required hours, the Committee pursued its accreditation of hospitals throughout the State to assure the continued availability of educational opportunity without necessitating out-of-state travel and a consequential loss-of-practice time. Presently there are 69 accredited hospitals in the State of New Jersey. Thirty-seven of these have been resurveyed, 15 of which were completed in 1977. During 1978, 29 hospitals will need to be resurveyed. These will be visited as soon as possible to make sure that physicians can obtain their Category I credits in their own hospitals.

Since there are a large number of physicians who use hospitals infrequently, as well as some who are house-bound within certain limits and others who live in areas where there are no accredited hospitals, the Committee investigated the

PREP program run by the College of Physicians of Philadelphia. This program enables the physician to obtain Category I credits without leaving his home or office. The subscription fee for this program is \$95. The Medical Society of New Jersey and the Academy of Medicine have combined their efforts to make this service available to physicians in New Jersey who find it impossible to earn their credits by the traditional method of meeting and course attendance.

Under these circumstances, the Committee feels that it has furnished every physician with simple, but effective means of earning meaningful Category I credits.

The AMA is no longer the primary accrediting agency for continuing medical education or accreditation of hospitals. This function has been delegated to the Liaison Committee on Continuing Medical Education which is made up of members from the American Board of Medical Specialties, American Hospital Association, American Medical Association, Association of Medical Colleges, the Council of Medical Specialty Societies, the Association for Hospital Medical Education, and the Federation of State Medical Boards. From this point, the Committee on Medical Education of the Medical Society of New Jersey must meet the requirements of the Liaison Committee on Medical Education rather than the AMA. It was felt that this system bypassed the practicing physician. The committees on medi-

cal education of the various state medical societies have, therefore, formed an active organization asking that they be represented on the Liaison Committee so that they may speak for the grass-roots physician practicing in all areas of the United States. The effectiveness of this protest remains to be seen. Currently the Liaison Committee on Medical Education has not evidenced any great interest in having representatives from the committees on medical education of the state medical societies. However, this will be pursued and we hope that ultimately there will be representation from the grass-roots physicians.

The Chairman wishes to thank the members of the Committee on Medical Education, the staff, and most of all, those physicians who have acted as surveyors for the hospitals' accreditation program since all of these people have worked long and diligently to try to make this program a success.

Filed in accordance with the recommendation of the Reference Committee. The Committee urged that the House take firm action regarding members who are delinquent in meeting their CME requirements.

Upon motion from the floor, the House directed that as of January 1, 1979, those physicians who are not in compliance with the CME requirements of the 1972 House of Delegates be dropped from the Medical Society of New Jersey.

Emergency Medical Care

Jack R. Karel, M.D., Chairman, Hillside

(Reference Committee "D")

Events occurring in our nation and abroad necessitated a Federal Health Preparedness Conference sponsored by Region II of the Federal Preparedness Agency, in which we participated. The conference permitted a comprehensive review of the manner in which federal and state agencies are carrying out their assigned responsibilities for emergency health preparedness. Recommendations were made to harmonize federal responsibilities, roles, and working relationships with state and local efforts. It is most important that all involved in emergency medicine or in disaster medical care "be prepared" at all times. We know not what the future holds for us.

STATE OF NEW JERSEY PLAN FOR EMERGENCY MASS CASUALTY CARE

After several months of meetings, a subcommittee met with representatives of the New Jersey Hospital Association, the New Jersey State First Aid Council, the New Jersey State Civil Defense and Disaster Control and the New Jersey State Department of Health, from which evolved a statewide Plan for Emergency Mass Casualty Care that was approved by the Board of Trustees. A conference was held on November 16, 1977 to publicize the contents of this plan. Copies of the plan have been mailed to component county medical societies, all hospitals in New Jersey, all district chairmen of the New Jersey State First Aid Council, county civil defense and disaster control coordinators, presidents

of county police and fire associations, county traffic officers' associations, county sheriffs, New Jersey State Police, and Commanding Generals of Fort Dix and Fort Monmouth. It is important to note that an Emergency Mass Casualty Care Plan is one of the 15 elements of a statewide plan for an Emergency Medical Services System.

MOPEDS

In view of the failure of the State Legislature, in the bill permitting anyone over 15 to drive motorized bicycles on most New Jersey roads, to include an important safety item—the requirement that the operator of these vehicles wear a safety helmet—the Committee recommended that the bill be amended accordingly. Upon approval by the Board of Trustees, the recommendation was forwarded to Governor Byrne.

EMERGENCY MEDICAL IDENTIFICATION

The Committee this year will repeat the Medic Alert Program that was highly successful in 1972 and one of the best in the nation. The EMI program tells anyone rendering emergency care to a person who is unconscious or otherwise unable to communicate that the bearer of the symbol has a condition requiring special attention. The symbol is used by many individuals who carry a special wallet card with vital information noted on it. Cooperation from hundreds of organizations and individuals is being obtained.

CATEGORIZATION OF HOSPITAL EMERGENCY CAPABILITIES

Since the original guidelines for four gradations or categories of hospital emergency services for adults, children and infants, including newborns, that could function in community systems of emergency medical capabilities were produced by a committee of the AMA, many changes have taken place and concerns have been expressed that necessitate a review of the present "state of the art." In this respect, a Conference on the Categorization of Hospital Emergency Capabilities will be held in mid-1978. The AMA is, therefore, seeking assistance in gathering categorization material in preparation for the conference. Since the Inter-Agency Commission on Emergency Medical Care's plan for emergency medical care contained a section on hospital emergency capabilities that included recommendations for changes in the four gradations, this entire section was forwarded to the Community Health Services Division of the AMA.

INTER-AGENCY COMMISSION ON EMERGENCY MEDICAL CARE—SEMINAR ON CLINICAL PUBLIC RELATIONS

A Seminar on Clinical Public Relations—Harmonizing Pre-Hospital and Emergency Room Relationships was held to bring together emergency service personnel to harmonize relationships in their conduct of pre-hospital emergency medical care. The seminar was well attended, especially by ambulance and rescue personnel. A similar program of this type may be offered again in the future.

ESSENTIAL EQUIPMENT FOR AMBULANCES

The Committee on Trauma of the American College of Surgeons has updated its list of essential ambulance equip-

ment. This list is the most widely accepted standard in the field of emergency ambulance service since 1961. Copies submitted by ICEMC to the New Jersey State First Aid Council have been well received and will be used as a guide by the districts to update their equipment according to the needs of their particular areas.

EMERGENCY DEPARTMENT NURSE TRAINING PROGRAM

The ICEMC was awarded a two-year federal grant from the Division of Medicine, Bureau of Health Manpower, USPHS, DHEW, for a Statewide Emergency Department Nurse Training Program. This program is expected to be the first of its kind in the nation. The curriculum was developed by an advisory body from the Emergency Department Nurses Association and the Committee on Training of ICEMC. There is a need for the training of nurses for duty in hospital emergency departments so that they have a greater capability to cope with the varied emergency medical and surgical conditions and can free the emergency physician to give more rapid and efficient service. The course will consist of five weeks of didactic and clinical specialized training to be given over a five-month period. Only registered nurses will be enrolled in this course. Hospitals and nurses throughout the state have been notified of the program. Didactic training will be conducted in the following nursing schools: The Mountainside Hospital, Montclair; Saint Francis Medical Center, Trenton; Helene Fuld Medical Center, Trenton; and West Jersey Hospital, Camden. In addition, hospital emergency departments in the State will be utilized for clinical training and experience. The first class was scheduled for March 6, 1978. The second class will start on September 6, 1978.

Filed in accordance with the recommendation of the Reference Committee.

Medicine and Religion

Thomas H. McGlade, M.D., Chairman, Camden

(Reference Committee "D")

The first Prayer Breakfast which was held during the Annual Meeting in May 1977 was well attended and well received. Due to the interest shown by the membership, it was decided to have the Breakfast become an annual event.

A planning meeting of the Committee was scheduled in November at the Society's Headquarters. The Reverend Doctor D. Reginald Thomas, of Ocean City, accepted the

invitation to be the speaker at the Breakfast. The program also will include readings from the Old and New Testaments.

The Committee anticipates another brief, inspirational Prayer Breakfast in May 1978.

Filed in accordance with the recommendation of the Reference Committee.

Resolutions

#6

Establish Family Practice Department at the
College of Medicine and Dentistry of New Jersey —
New Jersey Medical School

From the Essex County Medical Society
(Reference Committee "D")

Whereas, the fact that there is a shortage of family physicians in the State of New Jersey has been well documented; and

Whereas, the National Commission on the Cost of Medical Care recommends that, "There should be an increase in the proportion of family practice physicians because an increase could be expected to contribute to the moderation of rising health care costs in two ways:

(a) Through the substitution of physicians trained to the delivery of primary care for more specialized physicians who are likely to provide more expensive primary medical services, and

(b) Through lower training costs for a given supply of physician manpower or, conversely, a larger supply for the same level of costs."; and

Whereas, family practice provides not only primary care, but also the connective links between primary, secondary, and tertiary care; and

Whereas, the College of Medicine and Dentistry of New Jersey — New Jersey Medical School program on "Primary Care" is no substitute for the teaching of this continuity of patient care; and

Whereas, the present medical educational structure at the College of Medicine and Dentistry of New Jersey — New Jersey Medical School discourages interested students from selecting a career in family practice; now therefore be it

RESOLVED, that the Medical Society of New Jersey petition the New Jersey Medical School to establish a curriculum which would provide adequate teaching of medical students by family practioners during the second, third, and fourth years of medical school.

Adopted in accordance with the recommendation of the Reference Committee. The Committee suggested that the Board of Trustees seek the proper avenue of implementation and that Resolution #6 be presented to the Dean and the Academic Policy Committee of the College of Medicine and Dentistry — New Jersey Medical School in Newark.

#20

Opposition to Construction of
Osteopathic Building in South Jersey

From the Camden County Medical Society
(Reference Committee "D")

Whereas, there has been delay in the development of the allopathic clinical campus in southern New Jersey for various reasons; and

Whereas, there is definite evidence the osteopathic college is concurrently developing, including the building of a basic science building in Camden County; and

Whereas, a huge basic science building is already in existence capable of training both allopathic and osteopathic students; and

Whereas, such new structure would be unnecessary and a waste of taxpayers' money; and

Whereas, this would increase the cost of medical education in New Jersey; now therefore be it

RESOLVED, that this House of Delegates instruct the Board of Trustees to oppose this construction in South Jersey as unnecessary and an expensive waste of taxpayers' money; and be it further

RESOLVED, that the Board be instructed to oppose any legislation that may be introduced in the State Legislature concerning the building of an osteopathic basic science structure.

(See Substitute Resolution #20 offered by the sponsor)

Substitute #20

Shared Use of the Proposed Basic Science Facility in South Jersey by Both Allopathic and Osteopathic Students

From the Camden County Medical Society

(Reference Committee "E")

Whereas, the South Jersey Medical Education Program is developing rapidly with both allopathic and osteopathic components; and

Whereas, we, as physicians, should demonstrate the principles of efficiency and economy in the sharing of medical facilities; and

Whereas, the College of Medicine and Dentistry of New Jersey has proposed a basic science facility in South Jersey that will be used exclusively by osteopathic medical students; therefore be it

RESOLVED, that the House of Delegates insists that the use of any basic science facility in South Jersey be dedicated to the mutual use of allopathic and osteopathic programs;

and be it further

RESOLVED, that the House of Delegates instruct the Board of Trustees to actively project to the State Legislators the deep concern of this House.

The Reference Committee recommendation, which was not accepted by the House, was to reject both Resolution #20 and Substitute Resolution #20.

Upon motion from the floor the following was added to Substitute #20 as a third "Resolved."

; and be it further

RESOLVED, that a copy of this resolution be forwarded to the Board of Trustees of the College of Medicine and Dentistry of New Jersey.

Adopted as amended by the House.

REFERENCE COMMITTEE "E"

William J. D'Elia, M.D., Monmouth
Chairman

Thomas E. Mattingly, M.D., Burlington

Philip A. Passalacqua, M.D., Essex

Charles I. Nadel, M.D., Essex

Thomas A. Noone, M.D., Camden

Carolyn W. Watson, M.D., Essex

Alternate Member

Reports:

Council on Legislation

Council on Public Relations

Resolutions #7, #8, #9, #10, #11

Legislation

Daniel J. O'Regan, M.D., Chairman, Jersey City

(Reference Committee "E")

This report presents a summary of the ultimate status of legislative measures of primary concern to the Society during the second session of the 1977 Legislature. The Council's operations, together with a cumulative report of MSNJ's official positions on current legislation, are reflected regularly in official bulletins dispatched to State Legislative Keymen and to component societies, and in items published in the *Membership Newsletter* and *The Journal*. The minutes of the meetings of the Board of Trustees include full reports of the Council's actions taken in regular meetings.

The Council on Legislation continues its established policy of inviting an official representative from each specialty society to all Council meetings.

Although a notice announcing the date of each of the Council's meetings is sent to all MSNJ's official intermediaries with New Jersey specialty societies, the attendance of those representatives at the Council meetings remains small. The Council urges that more representatives attend its meetings so that it may have the benefit of the timely thinking of specialty societies concerning proposed legislation affecting the specialty fields.

The Council on Legislation agreed that in order to fortify our stand on legislative bills and make our position known throughout the Society it be a standing policy to invite the chairman of each Council and Standing Committee to attend the legislative meetings and to give them the right, if they cannot attend, to select a representative.

Of the bills reported to the House in 1977, the following were signed into law:

APPROVED

S-722 — To provide that graduates of accelerated courses in approved colleges of podiatric medicine and surgery shall be eligible for licensure in New Jersey.

S-1010 — To add a second consumer member to represent the public on the 19 professional and occupational boards under the jurisdiction of the Attorney General and the Commissioners of Insurance and Environmental Protection.

S-1387 — To provide for the establishment of a Graduate Medical Education Program.

S-1404 — To provide for confidentiality of child abuse reports and information; to provide penalties for violations.

S-1423 — To revise penalties for driving while intoxicated; to reduce

.15% to .10% alcohol in defendant's blood to presume intoxication; to provide for a program of alcohol education or rehabilitation.

S-1758 — To require the reporting of cancer cases and to establish a registry.

A-1718 — To provide for the inclusion of benefits for the treatment of alcoholism in hospital service corporation contracts.

A-1719 — To provide for the inclusion of benefits for the treatment of alcoholism in group health insurance contracts.

A-1720 — To provide for the inclusion of benefits for the treatment of alcoholism in medical service corporation contracts.

A-1722 — To provide for the inclusion of benefits for the treatment of alcoholism in health insurance contracts.

A-2021 — To provide for a Prescription Drug Price and Quality Stabilization Act, to provide for substitutions of prescription drugs and for advertising; to appropriate \$75,000.

A-3364 — Permits possession of ten days' supply of controlled dangerous substances under certain conditions.

DISAPPROVED

A-1659 — Requires, on the Premarital Certificate Form, as identification of whether the applicant ever has had rubella.

ACTIVE OPPOSITION

S-720 — To delete certain restrictive provisions in the definition of podiatry under R.S. 45:5-7 permitting the surgical scope of the practice to embrace the entire foot.

S-889 — To require physicians to report to the county prosecutor cases of suspected child abuse.

A-1898 — To provide that medical services rendered by a licensed chiropractor shall be included in the benefits of medical service corporation.

A-3295 — Concerns the use of laetrile in treatment of cancer.

The following bills of medical interest were introduced in the 1977 Legislature, but too late to be reported to the 1977 House of Delegates.

S-3173 Menza — (Creates A Separate Department of Mental Health and Disabilities at the Cabinet Level)

"Mental Illness" means a mental, emotional or behavioral affliction which is of such kind and degree as to require specialized care but does not include developmental disability.

"Developmental Disability" means a disability originating before an individual attains 18 years of age which is of indefinite duration and produces a substantial handicap attributable to mental retardation, cerebral palsy, epilepsy, autism, or other conditions as determined by the Commissioner.

The "Commissioner" shall be appointed by the Governor with the advice and consent of the Senate and shall be qualified "by experience and training to perform the duties of his office."

Each division will be under the supervision of a Deputy Commissioner appointed by the Commissioner. Each Deputy Commissioner shall be appointed by "training and experience to perform the duties of his office."

All functions, powers and duties of the Department of Human Services relating to mental health, mental retardation, and developmental disabilities are transferred to the Department of Mental Health and Disabilities. **ACTION DEFERRED**, pending further information from the Council on Mental Health and the Committee on Child Health.

S-3182 – Dodd and 25 others (Catastrophic Health Insurance Plan Act)

This bill creates a Catastrophic Health Insurance mechanism, authorizing a principle similar to that employed in A-1552 for professional liability insurance. The initial application of catastrophic coverage involves layered payments over and above regular health insurance coverage payments or a paid deductible.

Payments used to pay benefits for individuals claiming through the fund would then be billed against a claim pool of health insurance carriers. The carriers in turn would be permitted to pass on the cost to their subscribers by means of a surcharge. **APPROVED**.

It was recommended that the Board of Trustees propose a strong support of Catastrophic Coverage as a supplement to basic health insurance.

S-3289 – Russo (Same as the Assembly Laetrile Bill, A-3295)

This bill provides that it shall be lawful for physicians to prescribe, administer, and dispense laetrile upon the written request of the patient on a form which states "Amygdalin has not been approved as a treatment or a cure of cancer by the U.S.F.D.A."

A pharmacist shall be authorized to dispense amygdalin upon receipt of a proper prescription.

Questions related to injuries caused by such a prescription or failure to prescribe are not answered or addressed. Also the bill does not indicate how the pharmacist or the physician would come into possession of laetrile. **ACTIVE OPPOSITION**, because the drug has not been proved therapeutically valid for the treatment of cancer.

S-3298 – Dugan (A Supplement to the "Health Care Facilities Planning Act")

Any rule or regulation of the Department of Health notwithstanding, no health care facility shall be denied a license or certificate of need for the operation of a maternity unit or the supplying of perinatal services if (a) in its past calendar year of operation the number of newborn deliveries exceeded 750 births; or (b) such health care facility was the only facility during the past calendar year operating a maternity unit or supplying perinatal services in a municipality with population in excess of 70,000. **APPROVED**

S-3354 – Imperiale (An Act Concerning the Prescribing, Administering or Dispensing of Amygdalin – Same as the Assembly Laetrile Bill A-3295, Senate Bill S-3289)

This bill provides that it shall be lawful for physicians to prescribe, administer, and dispense laetrile upon the written request of the patient on a form which states "Amygdalin has not been approved as a treatment or a cure of cancer by the U.S.F.D.A."

A pharmacist shall be authorized to dispense amygdalin upon receipt of a proper prescription.

Questions related to injuries caused by such a prescription or failure to prescribe are not answered or addressed. Also, the bill does not indicate how the pharmacist or the physician would come into possession of laetrile. **ACTIVE OPPOSITION**, because the drug has not been proved therapeutically valid for the treatment of cancer.

S-3381 – Wiley and 9 other sponsors (To Regulate the Establishment, Maintenance and Operation of Medical Service Corporations and Medical Service Plans)

Authorizes Medical Service Plans to issue separate riders to cover chiropractic services. **NO ACTION**

S-3413 – Maressa (Visual Re-examinations for Motor Vehicle Drivers License)

Amends existing law to permit all physicians to certify vision examinations. **APPROVED**

S-3450 – Bedell, Musto, Fay, Maressa, Hirkala, Dodd, Imperiale

Same as A-3570, which is the same as A-3568, except it is appli-

cable to Blue Shield coverage. **ACTION DEFERRED**, pending further information from Medical-Surgical Plan of New Jersey, New Jersey Hospital Association, and the Department of Health.

S-3451 – Bedell, Musto, Fay, Maressa, Hirkala, Dodd, Imperiale, Buehler

Same as A-3569, which is the same as A-3568, except it is applicable to individual health insurance policies. **ACTION DEFERRED**, pending further information from Medical-Surgical Plan of New Jersey, New Jersey Hospital Association, and the Department of Health.

S-3452 – Bedell, Musto, Fay, Maressa, Hirkala, Dodd, Imperiale

Same as A-3568 which amends the insurance code to provide that group health insurance policies may "at the option of the insured," provide reimbursement for any nursing services within the lawful scope of practice of a duly registered professional nurse. It precludes such payment, however, when the nurse is concurrently compensated by a health care provider. **ACTION DEFERRED**, pending further information from Medical-Surgical Plan of New Jersey, New Jersey Hospital Association, and the Department of Health.

A-3083 – Pellecchia, Gregorio, Aduato, Cali and Bornheimer (An Act to Amend the "New Jersey Medical Assistance and Health Services Act")

This bill expands Medicaid to the medically indigent.

APPROVED

A-3143 – HOLLENBECK (Nursing Homes)

Whenever any patient in a nursing home leaves the nursing home for purposes of hospitalization, he shall, upon his release from the hospital, be entitled to return to said nursing home, and if no bed is available at the time of his release, he shall be given first preference for readmission to the nursing home. **APPROVED**

A-3295 – Gregorio (Prescribing, Administering, and Dispensing of Laetrile)

This bill provides that it shall be lawful for physicians to prescribe, administer, and dispense laetrile upon the written request of the patient on a form which states "Amygdalin has not been approved as a treatment or a cure of cancer by the U.S.F.D.A."

A pharmacist shall be authorized to dispense amygdalin upon receipt of a proper prescription.

Questions related to injuries caused by such a prescription or failure to prescribe are not answered or addressed. Also the bill does not indicate how the pharmacist or the physician would come into possession of laetrile. **ACTIVE OPPOSITION**, because the drug has not been proved therapeutically valid for the treatment of cancer. Law, c. 318 (1977)

A-3364 – Spizziri and 17 other sponsors (An Act to Amend the "New Jersey Controlled Dangerous Substance Act.")

This bill would amend the existing law to allow an individual to possess a one day's supply of a prescribed, sold or dispensed controlled dangerous substance either for himself or an animal of which he is the owner, in other than the original container under the following conditions. He must have on his person the name and complete address of the practitioner or veterinarian who dispensed the substance and an identifying number under which the prescription is recorded, together with the name of the practitioner or veterinarian prescribing it, the name of the substance, and the directions for the use of the prescription by the individual or his animal.

APPROVED

A-3482 – Kean (Scoliosis)

Mandates boards of education to conduct annual screening examinations of pupils between the ages of 10-18. Suspected cases are to be reported to the parents or guardians. **APPROVED**

A-3488 – Deverin (Respiratory Therapists)

Provides for the licensing and regulation of respiratory therapists and technicians under the auspices of the State Board of Medical Examiners. Provision of services other than under the direction or supervision of a physician shall be cause for revocation of licensure. **DISAPPROVED**, because the Society is not in favor of further individual licensure of ancillary personnel that must be relied upon by the practicing physician. The answer to the problem is not to license them individually, but to recognize the right of the physician to utilize the personnel that he recognizes as competent and for whom he assumes responsibility.

A-3502 – Villane (Medicaid)

Extends Medicaid coverage to "items" determined by the treating physician to be "medically necessary." **NO ACTION**

A-3510 – Shapiro (Medicaid)

Provides that abortion services shall be compensable under the Medicaid Program. **APPROVED**

A-3523—Otlowski, Karcher

To provide for the involuntary commitment of persons for treatment of mental disorders. **ACTION DEFERRED**, until copy of bill is available and information is received from the Council on Mental Health.

A-3533—Villane, Muhler, Saxton, Kennedy

To require the Department of Human Services to inform local health agencies whenever it places a former patient of a State psychiatric hospital in a residential facility within their jurisdiction. **ACTION DEFERRED**, pending further information from the Council on Mental Health.

A-3549—Doyle, Newman

To exempt from the requirement of obtaining a certificate of necessity any non-profit entity which had been chartered and acquired land to construct a hospital prior to enactment of the Health Care Facilities Planning Act when the land acquired is within a municipality that provided an appropriation for construction of a health care facility. **NO ACTION**

A-3561—Gregorio, Deverin

Would extend the Good Samaritan Act clearly to cover emergency transport personnel. **APPROVED**

A-3568—Bornheimer and 12 other Sponsors

Amends the insurance code to provide that group health insurance policies may "at the option of the insured," provide reimbursement for any nursing services within the lawful scope of practice of a duly registered professional nurse. It precludes such payment, however, when the nurse is concurrently compensated by a health care provider. **ACTION DEFERRED**, pending further information from Medical-Surgical Plan of New Jersey, New Jersey Hospital Association, and the Department of Health.

A-3569—Bornheimer and 13 other Sponsors

Same as A-3568 except it is applicable to individual health in-

surance policies. **ACTION DEFERRED**, pending further information from Medical-Surgical Plan of New Jersey, New Jersey Hospital Association, and the Department of Health.

A-3570—Bornheimer and 13 other Sponsors

Same as A-3568 except it is applicable to Blue Shield Coverage. **ACTION DEFERRED**, pending further information from Medical-Surgical Plan of New Jersey, New Jersey Hospital Association, and the Department of Health.

A-3571—Burstein and 12 other Sponsors

Creates a 12-person committee to study and oversee State appropriations for public general hospitals. Four of the members would be from the general public, the other eight from the Legislature. The Committee will report annually to the Legislature. **APPROVED**

A-3574—Burgio and 18 other Sponsors

This bill would require the State to conduct an annual audit of the financial records of providers of care to Medicaid recipients applicable to Medicaid payments. **NO ACTION**

PROFESSIONAL LIABILITY LEGISLATION

The Garramone Package (S-1240-S-1246) which passed in the Senate became stalled in the Assembly Committee on Institutions, Health and Welfare and terminated with the 1977 Legislature.

The Society busily is pursuing the introduction of a new package and at this writing has meetings scheduled with the Governor and the legislative leadership.

Filed in accordance with the recommendation of the Reference Committee.

Supplemental Report

In January of 1978, the following bills were signed into law:

A-1706—Provides for the testing of newborn children for early detection of hypothyroidism. **ACTION DEFERRED**, pending further information from the Council on Mental Health. Law, c. 321 ('77)

A-2058—Appropriates \$3,000,000 to the Department of Health for support of the Jersey City Medical Center. **APPROVED** Law, c. 7 ('77)

In the afternoon of January 10, 1978, the First Annual Session (1978) of the 198th New Jersey Legislature was opened. As the Legislature presently is constituted, the Senate has a total of 40 members. The Senate is presently made up of 13 Republicans and 27 Democrats. The Assembly has a total of 80 members of whom 26 are Republicans and 54 are Democrats. By means of official legislative bulletins the Society's official positions on all current State Legislation regularly are called to the attention of legislators as well as of component societies, cooperating agencies, county keymen, and county society secretaries and executive secretaries.

The Society has adopted the following regular range of official positions concerning proposed legislation.

ACTIVE SUPPORT . . . All-out support of the measure.

ACTIVE OPPOSITION . . . All-out opposition for the measure.

CONDITIONAL APPROVAL . . . To indicate that the approval of the Society is conditional subject to the elimination of the unsatisfactory elements of the bill that are pointed out.

APPROVAL . . . Commended as satisfactory, but not actively supported.

DISAPPROVAL . . . Rejected as unsatisfactory, but not actively opposed.

CURRENT STATE LEGISLATION

The Council offers this Supplemental Report covering items dealt with since the compilation of its Annual Report.

S-14 Russo, et al. — Damages for Wrongful Death of Minors

This bill would allow damages related to factors other than pecuniary injuries in the wrongful death of minors with said damages to be limited to \$100,000. (Current case law does not recognize such a compensable event unless the estate of the minor proved actual lost wages or income producing activity.) If enacted, this bill could have the effect of escalating personal injury liability rates. **DISAPPROVED**, because only damages established by proof should be subject to award.

S-33 Russo — Determination of Death

Same as S-1039 (1976) **APPROVED**

S-43 Russo — Terminal Illness Assistance

Amends existing statutes relative to the Juvenile Terminal Illness Program to include all persons regardless of age. **NO ACTION**

S-45 Russo — Health Care Facilities

Requires hospital governing boards to regulate smoking within hospitals. Visitors and staff shall smoke only in designated areas and not in the presence of patients. Patients shall be assigned rooms according to smoking preferences. **APPROVED**

S-46 Russo — Physician Advertising

Permits physicians to place their names on signs or directory posts within reasonable proximity to the building wherein their office is located. **APPROVED**

S-49 Russo — Motor Vehicle Implied Consent

Would extend the implied consent law to include the taking of blood and urine samples for alcohol or drug determinations. Refusal to permit the sampling would carry the same penalty as refusal of the breath analysis test. **APPROVED**

S-58 Russo — Good Samaritan Act

Extends the immunities of the above act to cover physicians responding in good faith to emergency calls in all locations including

hospitals. **CONDITIONAL APPROVAL**, pending the amendment of "no compensation." This amendment to be forwarded to the sponsor.

S-127 McDonough — Health Care Malpractice Liability Act

Same as A-2375 of last year (1976-1977), the Maguire Bill

This bill was drafted by the Monmouth-Ocean County Medical Society project. It contains a number of very favorable concepts which thus have far proven to be unacceptable to the legislature, i.e., an absolute two-year occurrence on the Statute of Limitations; a limitation on pain and suffering compensation which is recoverable only when caused by a willful or grossly negligent act; a limitation on punitive damages of \$100,000.

Other areas of difficulty are that:

(1) All providers of health care must carry professional liability insurance (limits not specified).

(2) Only when insurance covering liability is reasonably available as determined by the Commissioner shall a provider be liable for malpractice. (No court, legislature, or regulator would allow this clause to be operative.) **ACTION DEFERRED**, pending introduction of administration bills.

S-189 Orechio, et al. — Medical Examination of School Pupils

Permits school officials to direct a student to be examined by any available physician if the student's private physician is not available in order to determine whether or not he/she is under the influence of a controlled dangerous substance. **APPROVED**

S-191 Orechio, et al. — Testing of Police Candidates

Mandates that police candidates successfully undergo interview or test by a licensed practicing psychologist or psychiatrist prior to appointment. **CONDITIONAL APPROVAL**, provided the language is amended to assure all tests are completed by or under the supervision of a psychiatrist.

S-198 Orechio, et al. — Drug Abuse Advisory Council Act — 1978

Would establish a New Jersey Drug Abuse Advisory Council in the Department of Health. Consists of 17 members — 8 ex-officio, 9 citizens — appointed by the Governor. Purpose: to comply with federal grant requirements. **NO ACTION**

S-199 Orechio, et al. — Child Abuse

Deletes the word "willful" from the statutory definition of abandonment. **NO ACTION** (correspondence to be forwarded to sponsor requesting that this bill be more clearly defined)

S-206 Orechio, et al. — School Buses

Requires school transport vehicles to be equipped with seat belts and protective padding. **APPROVED**

S-214 Orechio, Scardino — Department of Mental Health

Creates a Department of Mental Health and Disabilities to be responsible for all services for the mentally ill, the retarded and the developmentally disabled. There is no provision for medical or psychiatric leadership. **DISAPPROVED**, because this bill is unnecessary — its intent can be accomplished within existing structures.

S-215 Scardino, et al. — Child Abuse

Permits information received and stored in the Central Registry of the Division of Youth and Family Services to be released to social case workers, probation officers, law enforcement agencies, and others that the DYFS determines have a professional interest in the control of child abuse. **APPROVED**

S-217 Scardino, et al. — Insurance Coverage of Outpatient Mental Health Services

This bill requires HSP-MSP and commercial health insurers to make available riders for coverage of outpatient mental health services. **APPROVED**

S-218 Scardino, et al. — Insurance Coverage of Outpatient Mental Health Services — Same as S-217. APPROVED

S-219 Scardino, et al. — Insurance Coverage of Outpatient Mental Health Services — Same as S-217. APPROVED

S-220 Scardino, et al. — State Medical Examiner Act

Amends existing statutes to include as a medical examiner case the "deaths of children under 3 years of age where the suspected cause is sudden infant death syndrome." **CONDITIONAL APPROVAL**. The italicized language on lines 32-35 (of the bill) should be removed because it conflicts with the concept of the cases being within the jurisdiction of the medical examiner. Beyond that, an autopsy is necessary to establish that SID was the cause of death. The medical examiner and not the parents, therefore, must decide whether or not the autopsy can be waived.

S-221 Scardino, et al. — Personnel of Psychiatric Hospitals

Requires the Commissioner of Human Resources to establish a personnel screening program for all employees in psychiatric facilities that have direct contact with patients. **APPROVED**

S-222 Scardino, et al. — Long Term Health Care Facilities

Establishes a citation system for prompt assessment of sanctions in case of violations of existing laws, rules, and regulations relating to patient care.

Class A violations are those presenting imminent danger to patients and a fine of \$2,000-\$10,000 for each infraction that must be imposed.

Class B violations are those having a direct relationship to the health and safety of patients other than Class A violations. A \$500-\$2,500 fine is to be imposed but may be suspended if the violation is abated promptly.

Jurisdiction rests with the State Department of Health, Division of Health Facilities. **NO ACTION**

S-224 Scardino, et al. — Developmental Disabilities

"Mental illness" means a mental, emotional, or behavioral affliction which is of such kind and degree as to require specialized care but does not include developmental disability.

"Developmental disability" means a disability originating before an individual attains 18 years of age which is of indefinite duration and produces a substantial handicap attributable to mental retardation, cerebral palsy, epilepsy, autism, or other conditions as determined by the Commissioner.

The "Commissioner" shall be appointed by the Governor with the advice and consent of the Senate and shall be qualified "by experience and training to perform the duties of his office."

Each division will be under the supervision of a Deputy Commissioner appointed by the Commissioner. Each Deputy Commissioner shall be appointed by "training and experience to perform the duties of his office."

All functions, powers and duties of the Department of Human Services relating to mental health, mental retardation, and developmental disabilities are transferred to the Department of Mental Health and Disabilities. **DISAPPROVED**, because it removes community involvement from the operation of the psychiatric hospitals and carries no provision to assure that adequate medical and psychiatric expertise will be utilized in the structure and management of the proposed new Department.

S-225 Scardino, et al. — Community Mental Health Programs

Amends existing statutes by emphasizing the State's intent to encourage the development of community mental health programs. **NO ACTION**

S-230 Scardino, et al. — Department of Public Advocate

Restructures the Division of Mental Health Advocacy within the Department to create a Division of Mental Health Legal Counseling and Assistance which shall be staffed by multi-disciplined personnel.

Jurisdiction is all encompassing and relates to counseling, advising, and representing patients on all admissions, confinements, or retainments in mental health facilities, transfers, treatment, etc. The Division also will have the right to inspect and visit at any time any center, clinic, hospital or facility for patients who are mentally disordered. **DISAPPROVED** because it imposes an unmanageable entanglement on the voluntary admission of psychiatric patients and invades the privacy and confidentiality of patients and families who have voluntarily sought treatment. Ultimately, it will discourage patients who desperately need help from seeking assistance because of the stigma attached to becoming registered with a public agency for voluntarily seeking psychiatric care.

S-231 Scardino — Mental Treatment Standards Committee and Patient Treatment Review Board

The proposed committee will consist of seven New Jersey residents, one psychiatric social worker, two psychiatrists, one psychiatric nurse, the Director of the Division of Mental Health and Hospitals, one administrator of a community mental health facility, and one licensed psychologist.

The Committee shall prepare a recommended "Manual of Adequate Standards for Treatment of the Mentally Ill in State Mental Institutions." The standards recommended by the Committee shall be expressed in as objective terms as possible.

This also has created a Patient Treatment Review Board, consisting of one psychiatrist, one non-psychiatrist M.D., one licensed psychologist, one psychiatric R.N., and one licensed attorney. The board shall review patient complaints and recommend such action as may be necessary to compel adequate treatment. **ACTIVE OPPOSITION**, because the Director of the Division of Mental Health and Hospitals should not be a member of the Mental Treatment Standards Committee. Funds are not specified to implement the program. Arbitrary decisions are allowed and the Committee has no way to enforce its own recommendations. Above all, it should be

noted that adequate review mechanisms already exist and function well.

S-241 Scardino — Abortions

Requires the attendance of a second physician at all abortions after the 20th week of gestation in case the child is born alive. **DIS-APPROVED**, because the bill is inconsistent since an abortion is performed to destroy the fetus and not preserve it.

S-244 Scardino — Abortion

Prohibits the intrauterine injection of a hypertonic solution except where the physician has made a judgment that any other method imposes an unreasonable danger to the life of the woman. (Penalty—misdemeanor) **ACTIVE OPPOSITION**, because this bill legislates the practice of medicine.

S-279 Ewing — Ancillary Services

Authorizes the physician to delegate performance of limited procedures (unspecified) to certified technical aides. **ACTIVE OPPOSITION**, because the Society is opposed to the legislative recognition of any further ancillary personnel. It believes that current personnel i.e., professional nurses, could be better employed to perform the technical procedures indicated.

S-290 Ewing — Sex Education

Requires local boards of education to conduct an annual review of all sex education courses within their jurisdiction to consider amendments thereto. Would permit sex education as a non-co-educational course. **NO ACTION**

S-358 Zane — Terminal Illness Assistance

Appropriates \$500,000, and directs the Department of Health to establish a program for the care and treatment of those suffering from terminal illnesses. **NO ACTION**

S-359 Zane — Chronic Disease Control and Treatment

Amends the existing chronic disease control law to permit the Department of Health to purchase or provide treatment or financial assistance. **NO ACTION**

S-367 Zane — Guaranteed Medical Education Loan Program

Makes loan monies available to medical students. Those practicing in areas of designated shortage will be entitled to a credit reduction of 20% for each year of such service. **ACTIVE SUPPORT**

S-372 Zane — Eye Bank

Authorizes the Department of Health to provide \$25,000 to the Eye Institute at the United Hospital in Newark. **APPROVED**

S-395 Zane — Medicaid

Extends Medicaid coverage to the medical needy which is to be defined by regulations of the Department of Human Services. **APPROVED**

S-417 Hagedorn — Public Eating Places

Requires all public eating establishments to have at least one employee on duty at all times who is familiar with choking prevention techniques as described in a State Health Department brochure. **DISAPPROVED**, this procedure could prove to be injurious to the people because of the difficulty in training restaurant personnel.

S-419 Hagedorn, et al. — Equality Among Health Insurers

Would provide that all health insurers be governed by the same rules and regulations, i.e., Blue Cross vs. Commercial Carriers. **NO ACTION**

S-420 Hagedorn, et al. — Cost Containment

Creates a health care cost containment commission—9 members — (one member to be of "the medical profession"). The Commission shall hold public hearings and make recommendations and findings to the Governor and the legislature. **NO ACTION** (The Board requested that a letter be sent to the sponsor suggesting that the words "practicing physician" be substituted for "the medical profession.")

S-473 Maressa — Transfer of Inmates

Inmates of correctional facilities are not to be transferred to state mental health facilities unless a licensed psychiatrist has examined the individual and approved the transfer. **ACTION DEFERRED**, pending further information from the Council on Mental Health.

S-486 Maressa — Vision Examinations

Amends existing law to provide that in addition to optometrists and ophthalmologists any licensed physician may conduct the required vision examination. **APPROVED**

S-515 Feldman — Creates a Mental Health Study Commission

The 34 member commission is to recommend to the Governor a comprehensive plan for delivering mental health services in New Jersey.

Composition

Commissioner of Human Resources

Director of Mental Health and Hospitals

President of New Jersey Association for Mental Health

6 members of the New Jersey Association for Mental Health

Chairman of the Community Mental Health Board

Chairmen of Board of Trustees of Ancora, Greystone, Marlboro,

Trenton, Skillman, Brisbane and Menlo Park

President of the New Jersey Psychiatric Association

2 Senators

2 Assemblymen

4 Social Workers

2 members of the CMDNJ Department of Psychiatry

3 Community Mental Health Center Directors

3 citizens at large

ACTION DEFERRED, pending further information from the Council on Mental Health.

S-517 Feldman — Psychology Licensing Act

Current law permits the licensing of psychologists who have a doctoral degree in psychology or in the opinion of the licensing board "a closely allied field."

This would amend that section to state that the degree of Doctor of Philosophy in psychology, the degree of Doctor of Education in psychology, or the degree of Doctor of Psychology are all equivalents.

Also permits the licensing board to require continuing education for relicensure. **ACTION DEFERRED**, pending further information from the Council on Mental Health.

S-667 Lipman, Merlino — Health Insurance

Would make it unlawful for health insurers to refuse to issue policies solely because the prospective insured suffers from Sickle Cell Trait, Hemoglobin C Trait, Cooley's Anemia, Cystic Fibrosis, or Tay-Sachs Disease. **NO ACTION**

S-669 Lipman, Merlino — Life Insurance

Same as S-667 except it applies to "life insurers." **NO ACTION**

S-669 Lipman, Merlino — Employment

Would make it illegal to refuse to hire persons solely because they suffer from Sickle Cell Trait, Hemoglobin C Trait, Cooley's Anemia, Cystic Fibrosis, or Tay-Sachs Disease. **NO ACTION**

S-679 Lipman — Minor's Consent to Treatment

Amends existing law to allow minors who have been sexually assaulted (in the judgment of a treating physician) to consent to medical and surgical treatment. **APPROVED**

S-692 Skevin — Controlled Dangerous Substances

Provides that in order to control unauthorized prescriptions all prescriptions for controlled dangerous substances must be written on distinctive paper "serially numbered for each prescriber." Such prescription blanks shall not be transferable. **DISAPPROVED**, because this bill is impractical and impossible of implementation.

S-700 Skevin — Cancer Reporting

Makes cancer a reportable disease to the State Department of Health in order to collect adequate statistical data to develop an effective prevention program. **NO ACTION** (This bill is already current law)

S-703 Skevin — Radiology Services

Permits radiologists to bill patients for x-ray interpretations for amounts that are not covered under the persons's hospital service contract. **ACTION DEFERRED**, pending further information from the Radiological Society of New Jersey.

S-710 Skevin, et al. — Cancer Detection

Creates within the Department of Health a cancer detection program to include detection and treatment clinics, research, and training programs in cancer detection. **CONDITIONAL APPROV-AL**, provided the bill is amended to provide subsidization to existing detection, diagnostic and treatment facilities rather than to have the State unnecessarily and at great expense create and duplicate current programs.

S-723 Zane — Civil Immunity

Provides immunity from civil suit for the Medical Vision Advisory Panel and persons providing reports and recommendations with respect to a licensee's ability to safely operate a motor vehicle. **APPROVED**

S-735 Russo — Certificate of Need Exemption

Exempts non-profit entities from Certificate of Need requirements when (a) land acquisition predated the law and (b) the land is located within a municipality which appropriated funds for the construction of the facility. **NO ACTION**

S-777 Hirkala — Immunity for Peer Review

Same as S-903 (1976-1977)

Grants civil immunity for peer review activities, including those of professional societies. **ACTIVE SUPPORT**

SJR-3 Vreeland — Motor Vehicles

Requests the Division of Motor Vehicles to place a Uniform Anatomical Gift Act Clause on driver license forms. **APPROVED**

A-32 Burgio — Physician Shortage Act

Provides 25 scholarships annually on a competitive basis to students studying medicine who agree that upon completion of training they will practice in an area in New Jersey designated as having a physician shortage. (Each recipient is entitled to \$5,000.00 a year for not more than 4 academic years). **APPROVED**

A-65 Codey, et al. — Tay-Sachs Disease

Authorizes counties wherein there is no county home or hospital suitable for children afflicted with Tay-Sachs disease to appropriate \$5,000.00 per year for expenses incident to the diagnosis and treatment of those children residing in that county. **APPROVED**

A-76 Deverin, et al. — Medicaid

Expands Medicaid coverage to medically needy persons who are ineligible under the current law because their incomes are too high. **APPROVED**

A-78 Deverin, et al. — Local Health Services

Provides that municipalities may avoid implementation of the Local Health Services Act whenever State Health Aid is unavailable to local agencies via the State Department of Health. **APPROVED**

A-83 Deverin — Occupational Therapy Licensing Act

Creates a new class of licensed practitioners who would function independently and would be permitted to perform such services as the design, fabrication, and application of splints; sensorimotor activities; the use of specifically designed crafts; guidance in the selection and use of adaptive equipment; therapeutic activities to enhance functional performance; prevocational evaluation and training; and consultation concerning the adoption of physical environments for the handicapped. The State Board of Medical Examiners will exercise jurisdiction. **DISAPPROVED**, because this bill lacks the proper physician direction.

A-84 Deverin — Respiratory Therapist Act

Provides for the licensing and regulation of respiratory therapists and technicians under the auspices of the State Board of Medical Examiners. Provision of services other than under the direction or supervision of a physician shall be cause for revocation of licensure. **APPROVED**

A-115 Contillo, et al. — Cigarette Tax Act

The tax proceeds (.01c per pack) would be used to finance cancer research, diagnosis, and treatment in New Jersey. **APPROVED**

A-136 Gallo — Automobile Reparation Reform Act

Raises current ceilings under the bodily injury portion of the no-fault law. Places a limit on medical expense coverage to aggregate of \$50,000.

The Commissioner of Insurance is authorized to promulgate a schedule of the types of treatment and reasonable fees for medical services for the most common form of injuries arising out of motor vehicle accidents. In this regard, the Commissioner is to be assisted by a panel of medical, legal, and insurance experts appointed by him. **ACTIVE OPPOSITION**, because there are existing organizations in New Jersey that can promulgate a schedule for the types of treatment as called for in the bill, i.e., PSROs and the New Jersey Foundation for Health Care Evaluation.

A-161 Karcher — Revocation of Medical Licenses

Provides for the mandatory revocation of licenses to practice whenever the licensee has violated Federal or State narcotic drug laws. **ACTIVE OPPOSITION**, because many violations are technical in nature and do not warrant revocation of a license, but a lesser penalty. Current law grants the State Board of Medical Examiners to impose a suspension or revocation according to the gravity of the

offense and is preferable to this bill.

A-199 Visotcky — X-Ray Technicians

Makes it a misdemeanor knowingly to employ an X-Ray technician who does not possess a valid registration certificate. **APPROVED**

A-202 Visotcky — Non-Voluntary Mental Health Admissions Related to Drugs

Current law provides for reimbursement to hospitals for 15 day involuntary commitments. This would recognize reimbursement under the seven-day commitment statute. **APPROVED**

A-204 Visotcky — Microwave Ovens

Mandates public facilities to post a notice alerting persons having pacemakers to the proximate use of microwave ovens. **APPROVED**

A-205 Visotcky — Prescriptions

Requires the prescriber to indicate to the pharmacist whether or not the label shall include the name and nature of the drug. **APPROVED**

A-254 Martin — Scoliosis

Mandates school boards to conduct annual examinations of pupils to detect scoliosis. **APPROVED**

A-270 Maguire, Kozloski, Barry, and Other Sponsors

An Act concerning health care malpractice liability and health care malpractice liability insurance. (Same as S-127) **ACTION DEFERRED** (pending introduction of administration bills)

A-360 Weidel — Cigarette Tax

Imposes a 10c per pack tax on cigarettes to finance cancer research. **NO ACTION**

A-369 Doyle, Newman — Certificate of Need

Exempts nonprofit corporations that had land for hospital construction prior to May 1971 from the certificate of need legislation, provided the municipality wherein said land was located had made an appropriation for the hospital construction. **NO ACTION**

A-432 Shapiro, Dowd — Controlled Dangerous Substances

Decriminalizes marihuana by removing criminal sanctions from the personal possession and use of one ounce or less of marihuana or six grams or less of hashish. **NO ACTION**

A-437 Shapiro — Charitable Institutions

Persons serving without compensation on the boards of charitable institutions would be immune from liability for acts or omissions arising from the discharge of their duties. **NO ACTION**

A-443 Shapiro — Medicaid Abortion Services

Permits Medicaid payments for abortion services. **APPROVED**

A-463 Jackman, Gallo — Division of Consumer Health Services in the State Department of Health

This bill legislates divisional status to a branch of the Health Department currently functioning under executive prerogative. **NO ACTION**

A-481 Froude — Death With Dignity Act

Would permit adults to direct that in the event of a terminal illness no maintenance medical treatment is to be used to prolong life. **APPROVED**

A-482 Froude — Restrictive Covenants in Medical Practices

Would make restrictive covenants in medical practices null and void and otherwise unenforceable. **APPROVED**

A-540 Bassano, et al. — Determination of Rh Disease in the Newborn

Requires every licensed attending physician to secure a Rh factor test for every pregnant female prior to delivery or abortion, or within 24 hours after delivery or abortion. (No penalty is provided for failure to observe the requirements of this bill.) **NO ACTION** (no enforcement mechanism is provided. This bill is unnecessary since its intent is already well established medical procedure in New Jersey.)

Filed in accordance with the recommendation from the Reference Committee.

Public Relations

James A. Rogers, M.D., Chairman, Paterson

(Reference Committee "E")

The Council on Public Relations has continued its policy to respond to the mandates of the House of Delegates as well as to adapt to the PR needs of the Medical Society of New Jersey's membership.

Continuing projects:

- a. Publication and distribution of:
 - (1) *Membership Newsletter*.
 - (2) Monthly news media releases on public health and professional liability (statewide newspapers, radio and TV).
- b. Preparation and publication of special news releases and publicity as required from time to time, in furtherance of the Society's business, interest and activities, including:
 - (1) The Eye Health Screening Program.
 - (2) The Annual Meeting, to include the Governor's Conference on "Identification and Prevention of Environmentally Related Cancer—Is New Jersey #1 in Cancer?"
 - (3) Child Safety Week.
 - (4) Selected official programs and activities.
 - (5) Professional Liability—through newspaper articles explaining MSNJ's position on professional liability and the problems that are being reflected on patient care.
 - (6) Legislative Meetings—between MSNJ representatives and legislators regarding medical and health-related matters, such as professional liability, cost containment, and peer review. These meetings were also of value to promote rapport and better understanding through communication with the legislators.
 - (7) Continuing the work of re-establishment and updating the legislative keymen system for legislative public relation activities.
 - (8) JEMPAC—continued cooperation with the JEMPAC Committee in the preparation and dissemination of promotional material on JEMPAC needs and activities.
- c. The Information Center at the Annual Meeting for the issuance of press releases.
- d. The Golden Merit Award continues as an important function in recognizing the physicians in the State who have served 50 years or more. In 1977, 69 awards were bestowed making it a grand total of 1,009 since the awards inception in 1957. A new Certificate has been designed for 1978.
- e. Encouragement of the continuance—or establishment—of orientation programs for new members under the sponsorship of component societies.
- f. Encouragement of statewide emergency medical care coverage, particularly with reference to "Basic Concepts Underlying the Provision of Professional Medical Care" as adopted by the House of Delegates and printed in the Appendix Reference Information of the *Membership Directory*.
- g. Encouragement of increased voluntary blood donations.
- h. Encouragement of radio broadcasts under the auspices of component medical societies, as well as from the State

Society.

- i. Encouragement of medical TV programs of informational value to the public.
- j. Diabetes Detection Week.
- k. Placement services in *The Journal*.

Much credit for the work accomplished by the Council goes to the Staff of MSNJ and to the consultants of Paolin & Sweeney, Inc., and much has been accomplished. Films have been shown on TV dealing with Defensive Medicine and Malpractice, Hypertension, Drugs, Alcoholism, and Lung Cancer. A question and answer booklet on the Cost of Medical Care was prepared and offered to the public in conjunction with the programs. Almost all of these programs were shown as public service messages at no cost to the Society. For this the Council is grateful to the cooperating television stations both in Philadelphia and New Jersey, as well as in New York.

Two one-half-hour programs were presented on Channel 10 on the Joel Spivak show "Women in Medicine." Channel 6 produced two one-half-hour programs on the "Coronary Bypass Operation" utilizing New Jersey physicians and patients successfully treated with this operation.

It is important to note that first prize in the Liberty Bell Award of Creative Excellence was given to the Medical Society of New Jersey for the public service release on "Smoking."

The Staff has met with the personnel of CBS in New York to discuss possible public interest subjects for future TV programs.

Twenty-six newspapers throughout the State have carried monthly releases on the progress of medicine, the problems of medicine, and the professional liability issues. Many of the messages that appeared, as public service activities by the Society, in the newspapers as advertisement, also appeared in *Time*, *Newsweek*, *Sports Illustrated*, and the *U.S. News and World Report*.

Bill stuffers, based on the topics of the public service releases, have been prepared and are available to the county medical societies for use by the physicians of the county to send to their patients should they so desire. Unfortunately, to date, the response has been small and the Council urges greater participation in this program by the physicians.

The Organization Structure of the Medical Society of New Jersey has been prepared both in manual and in chart form. The chart explains the functions and services of the Society and is being distributed primarily to new members.

MSNJ staff, in cooperation with Paolin & Sweeney, has prepared a public relations manual explaining our activities on TV, radio, and press. This is primarily for distribution to the PR chairman of the county societies.

The Council worked in conjunction with the New Jersey Hospital Association in reviewing the scripts for the Tel-Med program. This program is designed for public education throughout the State. The topics are germane and of great interest. The program originated in California and has in the past ten years spread throughout the country. The first statewide program recently has been organized in New Jersey.

An important contribution by MSNJ has been "The Nursing Home Bill of Rights." This geriatric poster was released to 26 newspapers throughout the State and was very well received. A supply for distribution by the various counties is available on request.

The Council agreed that all advertising, whether free or

paid, should aim at:

- a. Improving our public image through information.
- b. Increasing physician participation in MSNJ activities.
- c. Improving physician attendance at county and state meetings.

The following is recommended to all our membership as incorporating the most effective methods for good public relations:

a. Please read the literature distributed including the *Newsletter*, *The Journal*, and special releases. This would do most to relieve the so-called "communications gap."

b. The county officers and secretaries should pass on to their membership the information contained in the minutes and other releases sent them.

c. More of the membership should participate, at all levels, particularly in the political scene.

d. Attendance at meetings of the presidents and presidents-elect should improve.

e. Trustees should be invited to meetings of the county societies.

f. Consideration should be given to county meetings with their local press representatives and with their local legislators.

g. The best public relations is on a one-to-one basis, not only with the press and with legislators, but most especially with patients—in the best tradition of medicine.

Filed in accordance with the recommendation of the Reference Committee.

Resolutions

#7

Physician and Administrative Non-Medical Personnel Immunity

From the Bergen County Medical Society

(Reference Committee "E")

Whereas, the problem of peer review often involves the help of Medical Society non-medical personnel who work under the direction of their physician committee; and

Whereas, all persons, medical and non-medical, serving on administrative committees of our Medical Societies may be exposed to legal action and suit; and

Whereas, the reporting of incompetent and/or unethical activity may result in legal liability; now therefore be it

RESOLVED, that the Medical Society of New Jersey support, develop, or cause to be introduced legislation granting

civil immunity to administrative non-medical personnel of the Medical Societies acting for the public good and involved in peer review and other administrative activities.

The intent of Resolutions #7 and #11 is embodied in Resolution #7 and the Reference Committee recommended adoption after inclusion of the following additional "Resolved:"

; and be it further

RESOLVED that the Medical Society of New Jersey support, develop, or cause to be introduced legislation granting civil immunity to those physicians involved in peer review and administrative activities.

Adopted as amended by the Reference Committee.

#8

Inform Public of Harmful Effects of Marijuana

From the Essex County Medical Society

(Reference Committee "E")

Whereas, alcoholism is presently our most serious drug problem; and

Whereas, marijuana has the potential of becoming an even greater problem, since it is being used by an uninformed public; and

Whereas, scientific studies worldwide have shown that chronic marijuana use causes inhibition of cellular growth, reduction in sperm production, development of abnormal sperm cells, interference of the synthesis of important genetic material in the cells, interference with the immune systems, destruction of chromosomes, abnormal embryonic

developments, and birth defects in experimental animals, and, above all, brain damage; and

Whereas, its widespread use by our youth as a means of coping with daily stresses of life is a cause of concern; and

Whereas, many people are under the false impression that marijuana is no more harmful than tobacco or alcohol; and

Whereas, education is needed to inform the public that decriminalization is not legalization nor medical approval for

its use as a drug; now therefore be it

RESOLVED, that the Medical Society of New Jersey utilize all available media to inform the public that marijuana is not a harmless nor innocuous drug; and be it further

RESOLVED, that the Medical Society of New Jersey advise the public that decriminalization is not legalization nor medical approval for its use as a drug.

Adopted in accordance with the recommendation of the Reference Committee.

#9

Oppose Physicians' Assistant Licensure

From the Essex County Medical Society

(Reference Committee "E")

Whereas, the training of physicians' assistants is an expense and one usually borne by the taxpayers; and

Whereas, no one has established a real need for the use of physicians' assistants in this State; and

Whereas, physicians' assistants do not in any way replace the needed service of primary care physicians; and

Whereas, the medical school should concentrate on providing sufficient primary care and family physicians for the public of New Jersey; now therefore be it

RESOLVED, that the Medical Society of New Jersey continue to oppose the licensure of physicians' assistants.

The Reference Committee was of the opinion that existing ancillary and allied health personnel, under appropriate physician direction, adequately can address the requirements of New Jersey patients and recommended adoption of Resolution #9 after amending the "Resolved" to read:

RESOLVED that the Medical Society of New Jersey continue to oppose the licensure and/or registration of physicians' assistants, because no definite need has been established.

Adopted as amended by the Reference Committee.

#10

Opposition to National Health Insurance

From Frank J. Primich, M.D., Delegate, Hudson County

(Reference Committee "E")

Whereas, governmental intrusion into the provision of health care has consistently created greater problems than it solved; and

Whereas, said intrusion has materially increased cost while adversely affecting delivery and quality of care; and

Whereas, such intrusion will ultimately destroy private practice, medical progress, and the overall economy of this country; and

Whereas the majority of members of the Medical Society of New Jersey are desirous of preserving the private practice of medicine, furthering medical progress, and maintaining economic solvency; and

Whereas, any further intrusion, no matter how innocuous it may appear, brings us closer to total governmental take-over; now therefore be it

RESOLVED, that the Medical Society of New Jersey go on record as being opposed to any form of National Health Insurance; and be it further

RESOLVED, that the Medical Society of New Jersey withdraw its support of H.R. 1818, the American Medical Association-sponsored version of National Health Insurance.

Referred to the Board of Trustees for study and report, in accordance with the recommendation of the Reference Committee.

#11 Physician Immunity

From the Bergen County Medical Society

(Reference Committee "E")

Whereas, the problems of peer review in all its ramifications may leave the reviewing physician exposed to legal action; and

Whereas, those serving on administrative committees may also be exposed to legal action; and

Whereas, the reporting of incompetent and unethical activity

may result in legal liability; now therefore be it

RESOLVED, that the Medical Society of New Jersey support, develop, or cause to be introduced legislation granting civil immunity to those physicians involved in peer review and administrative activities.

(Intent of Resolution #11 embodied in Resolution #7—see page Tr 60)

REFERENCE COMMITTEE "F"

William M. Chase, M.D., Essex
Chairman

Karl T. Franzoni, M.D., Mercer

August P. Ciell, M.D., Camden

John J. Pastore, M.D., Cumberland

Robert A. Weinstein, M.D., Sussex

Ira J. Holzman, M.D., Ocean

Alternate Member

Reports:

Board of Trustees' Items

Council on Medical Services and its

Special Committee on Occu-
pational Health, Workmen's Com-
pensation, and Rehabilitation

Committee on Medicaid

Membership Inquiry and Complaint
Committees

Council on Mental Health

Committee on Impaired Physicians

Resolutions #12, #13, #14, #22

Board of Trustees' Items

AD HOC COMMITTEE TO REVIEW NATIONAL
COMMISSION REPORT ON THE COST OF
MEDICAL CARE—Louis F. Albright, M.D., Chm.
(Reference Committee "F")

The Ad Hoc Committee was appointed to study the National Commission Report on the Cost of Medical Care and make recommendations to the Board of Trustees for an appropriate resolution to be referred to the New Jersey Delegates to the AMA for presentation at the Annual Meeting of the AMA in St. Louis, Missouri, in June 1978.

The National Commission Report was divided into sections and task forces were formed to review an assigned

section and report their views to the Committee. The task forces are in the process of reporting their views to the Committee and after the presentation of each task force a consensus of the Committee is formed.

The Committee will have its report prepared for presentation at the April meeting of the Board of Trustees.

Filed in accordance with the recommendation of the Reference Committee.

Report of the Study on the National Commission on the Cost of Health Care and Recommended Actions

The following preamble, recommended by the Reference Committee to be referred to the AMA Delegation for inclusion in the ultimate recommendations of the AMA House of Delegates, was adopted as amended by the House.

PREAMBLE

Basic factors which have a significant escalating influence on the cost of medical care and which have not received sufficient attention in the report of the National Commission on the Cost of Medical Care are as follows:

1. Monetary inflation (primarily due to governmental overspending).

Item #1 was deleted and the following substitute was approved by the House:

1. The Medical Society of New Jersey believes that the main reason for the increase in health care costs is the overspending of the United States Government. With a government deeply in debt (3/4 trillion) and having increased its own budget over 500 percent in the last seven years, it is impossible for any other segment of the economy to stay in fiscal balance.

2. Overregulation by government and attendant red tape.

3. Increased life span and marked increase in over-65 population. Medical costs for these individuals are three times that for age 19 to 65 and six times that for ages under 19.

4. Increased demands and expectations such as result from first dollar coverage and governmental intervention in the market place.

5. Increased cost of medical liability insurance.

6. Increased cost of services and supplies utilized by health care facilities and physicians.

7. Increases in capital expenditures and staffing costs related to technological advances in the health care field.

Adopted as amended by the House.

Section I—Strengthening Price Consciousness (Recommendations 1 through 8)

Rec. No.	Title	Comment	Recommended Action
1	Economic Incentives in Purchasing Insurance and Health Plans	Has 4 parts: A—Options for employees; B—Produce incentives to shop; C—Balance tax treatment of costs; D—Equity between self insurance and employer. (All had reservations about how public could be fully informed.)	Endorsement as Written

2	Consumer Cost Sharing	Federal aid has unbalanced competition between HMOs and fee-for-service practice. Unions are unalterably opposed to cost sharing.	Endorsement as Written
3	Fair Market Health Plan Competition	Keep the competition fair!	Endorsement as Written
4	Alternative Financing Arrangements		Endorsement as Written
5	Regional Physicians and Hospital Directories	Approved in principle. Questions raised as to who would pay for such directories and who would get them.	Non-Endorsement
6	Information on Alternative Health Care Plan Benefits	Has 2 parts: A—Provide consumers with information which compares all competing plans; B—"Truth in Insurance" stressed.	Endorsement as Written
7	Regulation of Insurance Carriers and Health Plans		Endorsement as Written
8	Assessment and Assurance of Quality	Has 3 parts: A—Research how to assess quality; B—Make information so obtained available to all; C—Recertification programs; D— <i>While the above represent valid concepts regarding quality assurance, it must be emphasized that the PSRO program must play a primary role in any determination of quality assurance. (Italics indicate amendment)</i>	Endorsement as Amended

Approved in accordance with the recommendation of the Reference Committee, after amendment by the House by adding item "D" to the comment on Recommendation 8.

The following preamble to Section II was presented from the floor and adopted by the House.

Preamble to Section II

The Medical Society of New Jersey recommends that this study relates to the cost effectiveness and awareness of medical care with the prime concern still being quality medical care.

Section II — Private Sector Cost Containment Initiatives (Recommendations 9 through 15)

Rec. No.	Title	Comment	Recommended Action
9	Reimbursement Levels for Providers		Endorsement as Written
10	Voluntary Cost Containment Program	Such a cost containment program is already under way in New Jersey. It is sponsored by the New Jersey Hospital Association and MSNJ.	Endorsement as Written
11	Reimbursement Restrictions	Must reduce expenditures for inappropriate care. Adequate utilization of ancillary services must be insisted on.	Non-Endorsement
12	Prospective Rate Setting for Hospitals	Urges the development of prospective reimbursement programs and programs creating incentives for cost consciousness. <i>Amended by changing "as" to "if"—"Payment to institutions on the basis of prospectively determined rates, and other payment systems which also create incentives for facilities to be more cost conscious, should be explored and implemented if their effectiveness becomes clear." (Italics denote word change.)</i>	Endorsement as Amended
13	Incentives to Limit Bed Capacity	<i>Amended by addition—"Such programs should also address themselves to the adequacy of alternatives to acute in-hospital care."</i>	Endorsement as Amended
14	Incentives to Provide Appropriate Care	Has 2 parts: A—Develop and disseminate criteria for appropriate care; B—Explore ways to put providers at risk for inappropriate care.	Endorsement as Written
15	Utilization in Appropriate Settings	Promotes balanced coverage of alternative services and settings in provision of health care. Penalize care in inappropriate settings.	Non-Endorsement

Reference Committee recommended approval of report on Section II and made the following comments: The Reference Committee believes that the determinations of appropriate care (item 11) will rest with local PSROs and interprets the aspect of "provider risk"

(item 14) to be limited solely to his own fee.

The Ad Hoc Committee's recommendation to endorse items 11 and 15 was amended by the Reference Committee to non-endorsement.

Section III – Guidelines for Regulation (Recommendations 16 through 25)

Rec. No.	Title	Comment	Recommended Action
16	Evaluating Public Utility Regulation and Exemptions From It	Has 2 parts: A – Suggests attempts using carefully controlled experiments to evaluate the effects; B – Provides for exemptions. (The title "Public Utility Regulation" was an unfortunate choice.)	Non-Endorsement
17	Review of Regulatory Process	Regulations of all kinds have significant cost impact. Measures must be taken to reduce the number of inspections, audits, surveys, and reports.	Endorsement as Written
18	Planning	The concept of planning is supported. Advocates continued monitoring as to effectiveness of certificate of need programs. Suggests coverage be restricted to expenditures over \$150,000.	Endorsement as Written
19	Certificate of Need	If certificate of need legislation proves to be effective for inpatient institutions, it should be expanded to provider settings outside the hospital, including physicians' offices.	Non-Endorsement
20	Decertification	If certificate of need legislation proves successful, it should be implemented to achieve decertification or conversion of facilities excessive for community needs.	Endorsement as Written
21	Supply Guidelines	Encourage development of guidelines on a regional basis to determine what health personnel and facilities are needed in various geographic areas to meet demands.	Endorsement as Written
22	Placement Review Criteria	Develop criteria for the placement of expensive facilities and capital equipment to be used by local health planning agencies. Develop criteria at national level.	Endorsement as Written
23	Regional Centers	Regionalization of high-cost specialized services and technologies should be implemented. Access to these facilities is to be available for all patients needing these facilities, and to all qualified physicians to treat their patients.	Endorsement as Written
24	Capital Expenditure Limits	Capital expenditure limits, such as those proposed in the Hospital Cost Containment Act of 1977, should not be enacted. Impact probably would be arbitrary and uneven.	Endorsement as Written
25	Criteria and Use of Practice Evaluation Techniques	Has 2 parts: A – Would urge reviewing boards associated with PSRO, medical audit, and so on, to develop local guidelines which more specifically define appropriate care; B – Would urge that the information gathered through review techniques be utilized more effectively to compare quality and cost efficiency of various treatment modalities, to achieve educational objectives, and to insure linkage with planning activities.	Endorsement as Written* (see exception)

Approved in accordance with the recommendation of the Reference Committee, after inclusion of the exception under item 25.

*Except for B-1 – "Extend review to both institutional and office-based ambulatory care settings."

Section IV – Cost Containment Measures Within Medical Practice (Recommendations 26 through 32)

Rec. No.	Title	Comment	Recommended Action
26	Diagnostic Findings	Advocates sharing diagnostic findings. Amended by addition of: "At the discretion of the attend-	Endorsement as Amended

		<i>ing physician, X-ray or laboratory studies done outside the hospital may be included on the hospital chart in lieu of hospital studies."</i> (Italics indicate amendment.)	
27	Second Opinions Prior to Surgery	Advocates evaluation as to cost effectiveness as well as long range medical effects for those who did not have surgery. Amended by addition of: " <i>Evaluation of these trial programs is to be conducted with adequate physician peer review.</i> " (Italics indicate amendment.)	Endorsement as Amended
28	Inappropriate Medical Care	The physician is the patient's agent. As such he is actually a consumer of medical resources.	Endorsement as Written
29	Disciplinary Measures for Physicians	Amended to read: " <i>The medical profession should be allowed, with legal immunity, to develop and implement effective means for dealing with those providers of medical services who are found to be abusing or defrauding the health care financing or delivery system.</i> " (Italics indicate amendment.)	Endorsement as Amended
30	Defensive Medicine	Part A—Amended by addition of: " <i>Under the present litigious climate, defensive medicine will continue to be a fact of life and may even increase in magnitude, notwithstanding any considerations of quality, medical necessity, and cost effectiveness. The only way to reduce the impact of defensive medicine is legislation on a national scale designed to consider the plight of physician defendants to a greater extent than heretofor and to recognize legislatively that medicine is not an exact science.</i> " (Italics indicate amendment.)	Endorsement of 30-A is Amended Endorsement of 30-B as Written
31	Preventive Services	Amended to read: "Encourage the development of policies and mechanisms that lead to continuity, coordination, continuous availability of patient care including professional preventive care and early-detection screening services, <i>and are cost effective.</i> " (Italics indicate amendment.)	Endorsement as Amended
32	Multiphasic Health Evaluations	Carefully controlled experiments should continue to be conducted to determine the cost effectiveness of such programs in diverse environments.	Endorsement as Written

Approved in accordance with the recommendation of the Reference Committee.

Section V — Supply and Distribution of Health Care Providers (Recommendations 33 through 41)

Rec. No.	Title	Comment	Recommended Action
33	Physician Supply	Amended by addition. There should be no new efforts to increase the number of medical school graduates until such time as necessity for change is clearly evident. <i>However, we would approve current planning and objectives in New Jersey.</i> (Italics indicate amendment.)	Endorsement as Amended
34	Professional Attractiveness	Efforts should be made to improve professional attractiveness of service in shortage areas.	Endorsement as Written
35	Loan Forgiveness and Scholarships	Less reliance on current loan forgiveness and scholarship programs as means to affect physician location decisions.	Endorsement as Written
36	Recruitment from Underserved Areas	Amended by addition. If state loan forgiveness programs are established, they should be coupled with admission programs which actively recruit students from rural and other underserved areas. The financial lever alone is insufficient to have a permanent influence on physician distribution. However, the joint effect of admissions and loan policies holds more promise of being successful since students who were raised in a rural environment are most likely to return there to practice, <i>provided applicant is qualified and has</i>	Endorsement as Amended

		<i>trained in a primary care environment.</i> (Italics indicate amendment.)	
37	Family Practice	Increase in proportion of family practice physicians.	Endorsement as Written
38	Curricula on Economics of Health Care	Amended by addition of subparagraph C. <i>C. Postgraduate courses on the economics of health care should be implemented. This could be incorporated into continuing medical education.</i> (Italics indicate amendment.)	Endorsement as Amended
39	Price Consciousness in the Hospital Setting	Hospital setting provides ongoing opportunity to reinforce physician's price consciousness.	Endorsement as Written
40	Modify Restrictions on Allied Health Personnel	Insufficient information — being held in abeyance.	Non-Endorsement
41	Reimbursement for Allied Health Personnel	Physicians or their institutions paid directly for services of allied health personnel.	Endorsement as Written

Approved in accordance with the recommendation of the Reference Committee.

Section VI— Research Guidelines (Recommendations 42 through 45)			
Rec. No.	Title	Comment	Recommended Action
42	Technology Assessment and Information Dissemination	2 parts: A—Expansion of efforts to assess health care technologies, and to collect and disseminate results; B—Establish central depository and clearinghouse.	Endorsement as Written
43	Limit Restrictions on Diffusion of New Technologies	2 parts: A—Existing restrictions on diffusion of new drugs and devices should not be expanded; B—Government has responsibility for assessing safety of new technology and disseminating findings.	Endorsement as Written
44	Basic Research	Increased funding for research toward basic scientific understanding of disease mechanisms.	Endorsement as Written
45	Research Toward Cost-Saving Innovations	Research toward solving technology-related cost problems.	Endorsement as Written

Approved in accordance with the recommendation of the Reference Committee.

Section VII— Consumer and Patient Education (Recommendations 46 through 48)			
Rec. No.	Title	Comment	Recommended Action
46	Health and Patient Education	Educational programs important in providing knowledge and assistance to consumers in making health care utilization decisions.	Endorsement as Written
47	Private Sector Involvement in Education	Development and implementation of effective educational programs.	Endorsement as Written
48	Healthful Lifestyles	Effective methods of communicating to consumers.	Endorsement as Written

Approved in accordance with the recommendation of the Reference Committee.

Approved the entire report as amended, with commendation to the Chairman, Louis F. Albright, M.D.

NEW JERSEY STEERING COMMITTEE ON COST CONTAINMENT (Reference Committee "F")

At a Joint Meeting of the Executive Committees of the Medical Society of New Jersey and the New Jersey Hospital Association, it was agreed that a committee should be formed to look at hospital costs, revenues, utilization, increases in prices from vendors, and other activities which would promote voluntary cost containment.

Membership on the committee is made up of representatives from the Medical Society of New Jersey and the New

Jersey Hospital Association.

Filed in accordance with the recommendation of the Reference Committee.

POLICY POSITION ON PREPAID HEALTH CARE (Reference Committee "F")

The Board voted to adopt the following resolution submitted by the New Jersey Foundation for Health Care Evaluation:

Whereas, activity in the prepaid concept of health care delivery is already present in ten areas of New Jersey; and

Whereas, additional areas in our State are becoming interested in organizing prepaid plans; and

Whereas, the additional stimuli of government, industry, and labor will tend to accelerate the promotion of the concept; and

Whereas, the New Jersey Foundation for Health Care Evaluation believes that the Individual Practice Association is the most desirable form of prepaid care for patients and physicians; now therefore be it

RESOLVED, that the New Jersey Foundation for Health Care Evaluation, in conjunction with the Medical Society of New Jersey, conduct an informational meeting on the concept of prepaid medical care in New Jersey; and be it further

RESOLVED, that officers and delegates of the component medical societies, as well as representatives of the specialty societies, be urged to participate in such a meeting, and in the study of desirable options of methods of delivery of care under the prepaid method.

Filed in accordance with the recommendation of the Reference Committee.

TASK FORCE TO REVIEW "MODEL HEALTH CARE SYSTEMS"

(Reference Committee "F")

A task force to review "Model Health Care Systems" was appointed to study and find ways and means to see what can be done to circumvent the implementation of the "Model Health Care System" as propounded by the Department of Health.

A meeting was held and members were assigned specific sections of the "Model Health Care System" to criticize.

Another meeting is planned to summarize the individual responses and to prepare a position paper.

Filed in accordance with the recommendation of the Reference Committee.

USE OF AMPHETAMINES

(Reference Committee "F")

Information was received from the New Jersey State Board of Medical Examiners concerning the use of amphetamines and the group of sympathomimetic amines in cases of narcolepsy, minimal brain dysfunction, and obesity.

The State Board of Medical Examiners was apprised of MSNJ's concern that, contrary to the opinion of the State Board, the specifics concerning the dispensing of prescriptions for amphetamines and/or its group of sympathomimetic amines for a period in excess of fourteen days are not common knowledge and should be disseminated to all practicing physicians, hospitals, and facilities in the State, and that retroactive application should not be applied.

The Society continues to press for the adoption of a valid and reasonable prospective regulation. It also has been suggested that the State Board consider designating *The Journal* as an official publication for notices, rule proposals, and rule adoptions pertaining to the practice of medicine.

The Executive Secretary of the State Board has advised that our communication was forwarded to all members of the State Board for consideration.

Filed in accordance with the recommendation of the Reference Committee.

HSA ACTIVITIES

(Reference Committee "F")

In February, the Board instructed the Executive Committee to devise a method of aiding in HSA activities.

The following recommendations of the Executive Committee were approved, as amended, by the Board:

a. That all county medical societies within each HSA area should develop close liaison with one another in terms of disseminating information and working together toward influencing HSA activities.

b. That each county medical society should designate, at least, a staff or board of trustees member whose function would be to review and comment to the county society on HSA activities.

c. That each county medical society, when it believes its local HSA to be acting in conflict with the concept of good health care delivery, should formally notify, in writing, the Medical Society of New Jersey.

d. That the Medical Society of New Jersey hire or designate a staff person to collate such reports, study their validity, and recommend appropriate action for consideration by MSNJ's Board of Trustees.

e. That the Medical Society of New Jersey, where indicated, act as an advocate of the local county society before the State Health Planning Commission in those instances where conflicts have not been resolved at the local level.

f. That all county medical societies and members of MSNJ through appropriate articles in *The Journal* of the Medical Society of New Jersey and its *Membership Newsletter* be implored to become knowledgeable and participate in the public meetings of their local HSAs.

Filed in accordance with the recommendation of the Reference Committee.

Medical Services

Victor H. Boogdanian, M.D., Chairman, New Brunswick

(Reference Committee "F")

The Council is charged with the responsibility of studying and evaluating matters relevant to maintenance and advancement of standards and character of medical practices in New Jersey, and the investigation of the economic and social aspects of medical care.

AD HOC COMMITTEE ON NUTRITION

(Howard N. Jacobson, M.D., Chairman)

Dr. Jacobson distributed the report entitled "The Reduction of Hospital Malnutrition" by Robyn Chernish, M.S. and Howard N. Jacobson, M.D., which is a project of the

Subcommittee on Nutrition, Committee on Public Health of the New York Academy of Medicine. After discussion of the importance of this report and of the Subcommittee's work, the Council on Medical Services recommended and the Board of Trustees concurred that Howard N. Jacobson, M.D., be appointed as the official representative of the Medical Society of New Jersey on the Subcommittee on Nutrition, Committee on Public Health, New York Academy of Medicine.

Weight Control Centers—Dr. Jacobson reviewed the status of the weight control centers and indicated that the State

Health Department is concerned with recent developments involving these centers and has asked for guidelines which the Department might follow when faced with an application for a Certificate of Need by one of these centers. The State Department of Health, in bringing these centers under the Certificate of Need mechanism, has in effect brought about endorsement of these facilities even though it is not intended to do so.

It was recommended and the Board of Trustees approved a communication being sent to the New Jersey State Department of Health expressing the concern of the Medical Society of New Jersey that, by the requirement of a Certificate of Need, the Department of Health is giving credence to free standing agencies, without control. Recent communication from the Department of Health informs us that weight control centers will *not* be considered "health care facilities," and, therefore, will not require a Certificate of Need. Other measures to regulate quality control will be implemented.

Presentation of Paper on Protein Supplemented Starvation

— Dr. Jacobson presented to the Council a copy of a report "Protein Supplemented Starvation" by Susan Sell, B.S., Mirriam K. Brush, Ph.D., and Howard N. Jacobson, M.D., in consultation with Theodore B. Van Itallie, M.D. It was the consensus of the Council that the use of these protein supplements as a sole source of food is premature, is still in the research stage, and should be treated as such. The Council recommended that the Medical Society of New Jersey notify all doctors in New Jersey and the New Jersey Department of Health that it is the opinion of the Council on Medical Services that diets using protein hydrolysates with or without added amino acids, vitamins or mineral supplements, as the sole source of calories for the purpose of weight reduction, should be regarded as an investigational procedure and not as a safe method of treatment. The State Department of Health issued an advisory on this topic. The Council also recommended distribution of the report to the AMA, and the American Heart Association.

1977 HOUSE OF DELEGATES REFERRAL — RESOLUTION #15 — ACCEPTANCE OF STANDARD CLAIM FORMS

The Council appointed a subcommittee to look into the acceptance of standard claim forms by the Medical Surgical Plan of New Jersey. Discussions have been held with representatives of the Health Insurance Council and other insurers to work out a feasible plan acceptable to all. When these discussions are complete, a full report will be given to the Council.

BOARD OF TRUSTEES REFERRAL — CAT SCANNERS

Charles L. Cuniff, M.D., representing Blue Shield, reviewed the history of Blue Shield's payment and fee schedules for CAT Scanners. He pointed out to the Council that the difference between reimbursements to hospitals and physicians was caused by a pilot program that was established by Blue Shield of New Jersey in February 1975. Since that time this program has been reviewed and revised several times. This pilot program has now been discontinued and reimbursement by Blue Cross to the hospitals and reimbursement by Blue Shield to the physicians are the same. The Council recommended that no further action on reimbursement for CAT Scanners be taken at the present time.

HEALTH CARE DELIVERY SYSTEMS

The Council reviewed and discussed extensively the various types of health care delivery systems in existence in New Jersey. The Council on Medical Services' findings are as follows:

The delivery of health care in New Jersey has many aspects and nuances. On the premises that: (1) freedom of choice of physicians is a desire of many patients; (2) the private practice of medicine and its resulting patient-physician relationship is a desire of both patient and physician; and (3) the prepaid concept, to include preventive care, is attractive to many elements of society and is being sponsored and encouraged by government, the Council on Medical Services recommended and the Board of Trustees approved that, in addition to the already established modes of practice, those doctors who desire to do so be encouraged to form IPA-HMO types of organizations with the marketing and promotion of such organizations being left to those best qualified and willing to undertake them.

COUNCIL ON MEDICAL SERVICES' SURVEY

The Council surveyed the Medical Society of New Jersey's membership asking for expression of opinion on pertinent questions and requesting a listing of those subjects the membership thinks the Council should explore. The response was very disappointing, representing less than four percent return. This suggests some interesting speculation:

1. Few physicians read *The Journal* of the Medical Society of New Jersey; and/or
2. Few physicians answer surveys even when made convenient and without cost; and/or
3. The questions asked did not interest and excite the physicians enough for them to answer; and/or
4. The membership does not have any subjects they feel the State organization should be exploring through this Council.

BOARD OF TRUSTEES REFERRAL — MSP COVERAGE OF ASSISTING SURGICAL FEES

The Council, after extended discussion and careful consideration, recommended and the Board of Trustees approved that the Medical Society of New Jersey should support the incorporation of the payment of assisting surgical fees into Blue Shield's basic contract; if this is impossible, the Medical Society of New Jersey should support the implementation of some method or methods to cover this cost for the patient's benefit.

BLUE SHIELD — MEDICAL NECESSITY PROGRAM

The project termed the "Medical Necessity Program" which has been undertaken by Blue Shield was explained to the Council. This is the program under which certain diagnostic studies and surgical procedures are paid only upon submission of appropriate justification. The Council recommended and the Board of Trustees concurred:

1. That in the promotion of quality care, the removal from the procedure code of items which have been determined locally and nationally to be obsolete be encouraged; and
2. That payment not be categorically denied, but after appropriate and timely notification of the profession, that payment be made only upon submission of a report satisfactorily establishing medical justification.

A similar recommendation was made and approved by the Board of Trustees concerning the revision of Rider J Laboratory Fee Schedule.

BOARD OF TRUSTEES REFERRAL – DISTRIBUTION OF MEDICAL CARE STUDY

It was suggested that a study be made to determine the distribution of medical care in the State of New Jersey. The purpose of the study would be to identify any possible lack of proper distribution of medical care, to define the lack, and recommend to the Board the manner in which deficiencies can be rectified. The Council is in the process of gathering all the necessary information and data so that a proper study of this problem can be reviewed by all members of the Council. A full report, when completed, will be submitted to the Board of Trustees.

MEDICAL SOCIETY OF NEW JERSEY REPRESENTATION AT ALL STATE GOVERNMENT MEETINGS

The Council, in its many deliberations, realizes that the medical profession and State Government will cross paths on many occasions. For this reason, discussion was held on the possible importance of having physician representation at meetings with all State Government departments pertaining to the medical profession. Specifically, the Council recommended, and the Board of Trustees approved, that the Medical Society of New Jersey appoint a representative to attend future meetings of the State Health Planning and Coordinating Council.

PREADMISSION TESTING OFFICE CONSULTATION (PATOC)

The Council is pleased to note that a pilot study is in

progress in Union County relative to the payment of consultation fees for consultations done in the consultant's office prior to admission to the hospital. The success or failure of this experiment will be reported as soon as feasible.

ELECTIVE SURGERY SECOND OPINION PROGRAM (ESSOP)

The Council noted with regret the premature release to the media by the Department of Insurance of interpretations of statistics gathered to date under this program. Any thinking individual will realize the base is too small and the time too short to draw any valid conclusions. Unfortunately the public will not be aware of these facts and may come to inaccurate inferences on the quality of surgical care.

Filed in accordance with the recommendation of the Reference Committee.

Occupational Health, Workmen's Compensation, and Rehabilitation

Elmer J. Elias, M.D., Chairman, Trenton

(Reference Committee "F")

The Committee has had no formal meeting this year and thus has no formal report to make to the House.

Reference Committee and House noted that the Committee had no report.

Medicaid

Harvey J. Shwed, M.D., Chairman, Newark

(Reference Committee "F")

The Medicaid Committee, which was formed as an Ad Hoc Committee of the Medical Society in response to the emergent issues of Medicaid cutbacks in August of 1975, is now a regular functioning Committee of MSNJ. It meets monthly with various representatives from the county medical societies, specialty medical groups, and invited guests representing other professional providers, along with the staff members of Medicaid (The Division of Medical Assistance and Health Services).

The Committee continued to serve as a forum for open discussion between the medical profession and other providers and the staff of Medicaid.

Issues that continue to be raised include:

1. Increasing bureaucratic demands on the part of Medicaid on the individual provider.
2. The low reimbursement rates.
3. Issues of confidentiality.

The Committee, however, has been successful in opening lines of communication between those who administer the Medicaid programs and those who provide the services. The Committee functions as the first avenue of discussion for issues. Examples of these include: (a) Use of the social security number as an identification number for each provider, which was rejected both by the Committee and the Board of Trustees; (b) Revision in thinking on the part of Medicaid as to the requirement that each physician, pharmacist, and so on include the personal identification number of each referring provider; (c) Opening an avenue for negotiation between specialty groups and Medicaid, for example, the orthopedic group.

The Committee was successful in working out a procedural plan for what transpires when Medicaid wishes to talk about an issue with a particular physician: (1) The physician should be informed both in writing and by phone to set

a mutually acceptable time. (2) The physician has a right to know beforehand what the issues are that will be discussed. (3) The physician has a right to bring anyone along with him. (4) The physician should be informed of who, from Medicaid, will be in attendance at that meeting. Medicaid agreed with these principles.

The staff of Medicaid recognizes that reimbursement rates are low and that private physicians may be increasingly reluctant to take on new Medicaid patients. The Committee has geared up for a program of legislative education particularly with the Appropriations Committees of both the Senate and the Assembly. Both groups have attempted to begin an analysis of "the cost of medical care"; however, this has been placed on the "back burner" at this time.

The Chairman of the Committee attended a three-day seminar in Orlando, Florida in which issues between Medi-

caid and provider groups throughout the United States were aired. Many of the similar problems that have been considered by our Committee generally were discussed in the three-day conference.

I would like to thank the members of the Committee for their cooperation and the staff of the Medical Society, particularly Mr. Joseph Lucci and his secretarial staff, for their invaluable assistance in making the task of the Committee easier. Committee members continue to publish articles which hopefully help to alter public opinion in the local press as well as in the professional journals (*The Newark Star Ledger*, *The Trenton Times*, *The Journal of MSNJ* and of the Osteopathic Society, and the *American Medical News*).

Filed (See Resolution #22, page Tr 74).

Membership Inquiry and Complaints

Joseph C. Lucci, Executive Assistant, Trenton

(Reference Committee "F")

INQUIRIES AND COMPLAINTS MARCH 9, 1977 TO MARCH 6, 1978

MEDICARE

The Committee had one meeting to consider a complaint. The report of this meeting is still pending. All other complaints were resolved to the satisfaction of the physicians involved. A total of ten complaints were received. One complaint is pending.

MEDICAID

This Committee did not meet formally, since all complaints were resolved to the satisfaction of the physicians. A total of twenty-two complaints were received. Sixteen complaints are pending. Of these, fifteen were submitted by one physician.

MEDICAL-SURGICAL PLAN OF NEW JERSEY

This Committee did not meet formally since all complaints were resolved to the satisfaction of the physicians. Twenty-three complaints were received. Two complaints are pending.

OTHER HEALTH INSURANCE CARRIERS

This Committee did not meet formally since all complaints were resolved to the satisfaction of the physicians. Seven complaints were received.

Filed in accordance with the recommendation of the Reference Committee.

Mental Health

Robert S. Garber, M.D., Chairman, Belle Mead

(Reference Committee "F")

The bulk of the Council's time this year has been occupied in the review and dissection of the rash of legislative referrals in the realm of mental health. We recommended *active opposition* to:

S-1719-Menza—"An Act Establishing a Mental Treatment Standards Committee."

S-3173-Menza—"Creates a Separate Department of Mental Health and Disabilities at the Cabinet Level."

S-3533-Villane, et al—"An Act Concerning the Placement of Former Patients of State Psychiatric

Hospitals and Residential Facilities."

From the constructive standpoint, we recommended that the Board of Trustees take an active position of introducing legislation that would prevent the warehousing of patients who do not have adequate supervision in after-care facilities.

Our Ad Hoc Committee Report on the New Jersey Mental Health Planning Commission's Final Report was mailed to approximately 250 individuals and/or organizations.

Filed in accordance with the recommendation of the Reference Committee.

Impaired Physicians

Arthur McLellan, M.D., Chairman, Summit

(Reference Committee "F")

This report represents a recapitulation of the development of the Impaired Physician Program of the Medical Society of New Jersey.

The Board of Trustees of the Medical Society at its November 21, 1976, meeting approved a recommendation submitted by the Council on Legislation that an Ad Hoc Committee be appointed with regard to the establishment of a program to assist impaired physicians. The Committee, as appointed, developed a proposal which was presented to the Board of Trustees on September 18, 1977. This proposal was approved by the Board for implementation and development.

It is anticipated that the Program for the Impaired Physician will be operational and implemented in all aspects in June of 1978. Currently, the activities of the Committee consist of development and consolidation of committee structure and membership, as well as training and consultation with regard to the implementation and operation of the plan.

The purpose of the Impaired Physician Program is to provide assistance to those physicians who have become impaired and as a result are unable to maintain a level of performance consistent with the expectations of the public, Medical Society, and State Licensing Board. The primary

goal of this Program is to provide constructive intervention resulting in the restitution of normal functioning. Whereas the primary goal is that of assisting the physician to recovery or to function within stated limitations, an equally important goal is to protect the public from those physicians who, for whatever reason, are unable to recover to a level of acceptable performance. Experience has shown that the welfare of the patient and the public are inseparable. The following categories of impairment are appropriate for consideration by this Program:

(1) Chemically Impaired: Substances of abuse include alcohol, narcotics, sedatives, and other chemicals which result in impairment of function.

(2) Mentally Impaired: Organic brain disease and psychiatric disorder which interfere with performance.

(3) Physically Impaired: Medical conditions which limit ability to function adequately.

Inadequate Physician: This category which includes the inept, the unethical, and the dishonest is specifically considered *not* appropriate for the *Impaired Physician Program*.

Filed in accordance with the recommendation of the Reference Committee (See Resolution #12, below).

Resolutions

#12

Committee on Impaired Physicians

From the Committee on Impaired Physicians and the Board of Trustees

(Reference Committee "F")

Whereas, the Impaired Physicians Committee of the Medical Society of New Jersey has been formed; and

Whereas, the operative plans of the Committee have been drawn up, modified, and approved by the Board of Trustees; and

Whereas, the first major task of the Committee will be case finding; now therefore be it

RESOLVED, that the House of Delegates take steps to disseminate information regarding the existence of the Com-

mittee and its non-punitive, therapeutic, and advocacy approach to the impaired physician. These steps shall include special communications to each County Medical Society, the State and County Osteopathic organizations, the State and County Medical Society Women's Auxiliaries, the New Jersey Hospital Association and each hospital administrator in the State, every licensed M.D. and D.O. in New Jersey, the appropriate State and County Nursing and Pharmacy organizations, and all other pertinent organizations and individuals.

Adopted in accordance with the recommendation of the Reference Committee.

#13

Governmental Regulation — Health Care Cost Escalation

From the Hudson County Medical Society

(Reference Committee "F")

Whereas, the vast majority of patients are satisfied with the quality of health care that they receive; and

Whereas, most of those patients are justifiably concerned with cost containment; and

Whereas, patients, doctors, hospitals, lawyers, insurance companies, the pharmaceutical industry, labor unions, and many other groups contribute in small degree to unnecessary escalation of costs; and

Whereas, the National Commission on the Cost of Medical Care, in 48 recommendations, neglected to mention the overwhelming major cause of skyrocketing costs, our government, through government-caused inflation, clerical costs of compliance with bureaucratic regulations, legislative inaction and judicial interpretations which have permitted medical liability costs to approach prohibitive levels, political promises of a currently unattainable degree of health maintenance, and last but not least, the huge cost of administering innumerable regulatory agencies; and

Whereas, physicians, feeling guilt for our admitted shortcomings, and attempting to maintain a "non-political" posture, have not only permitted but contributed to making our profession the number one scapegoat; now therefore be it

RESOLVED, that the Medical Society of New Jersey be the first state medical society to have the courage to lay the blame where it belongs, on government intrusion; and be it further

RESOLVED, that our public relations efforts be directed toward informing the public, our patients, of the visible and hidden costs of current and proposed governmental actions.

Reference Committee agreed with the intent of Resolution #13, but felt that the objectives had been accomplished by adoption of the recommended preamble to the National Commission Report on the Cost of Medical Care, and recommended rejection.

Upon motion from the floor Recommendation #13 was adopted by the House.

#14

Group Health Services, Inc.

From Mercer County Medical Society

(Reference Committee "F")

Whereas, patients receiving health care are best served by being able to obtain the physician of his or her choice; and

Whereas, the Group Health Services, Inc. (New York, N.Y.), a health insurance company providing coverage for federal employees, has circulated a letter stating that after January 1, 1978, its "new program payments for services rendered by nonparticipants will be reduced by 50 percent of GHI's new schedule as required by the Federal program"; and

Whereas, if this discriminatory fee schedule is allowed to stand it will encourage other third party carriers to do the same; now therefore be it

RESOLVED, that the House of Delegates of the Medical

Society of New Jersey endorse and promulgate through its *Journal* and other mailings, the AMA position of approval of Resolution #64 adopted at its December 1977 meeting, which reads as follows:

"RESOLVED, that the AMA oppose third party differential between services covered by participating and nonparticipating physicians as discriminatory and against a physician who does not have a separate contractual relationship with the carrier and inhibiting the patient's free choice of physician; and be it further

RESOLVED, that this position be communicated to all health insurance carriers."

Adopted in accordance with the recommendation of the Reference Committee.

Medicaid Funding and Provider Reimbursement

From John Winslow, M.D., Delegate, Essex County
(Reference Committee "F")

Whereas, Medicaid of New Jersey recommended an increase of eighteen million dollars in order to reimburse providers in an appropriate fashion and commensurate with increased costs; and

Whereas, this amount was decreased to approximately eight million dollars by the Commissioner of the Department of Human Resources of the State of New Jersey; and

Whereas, the Governor of the State of New Jersey has seen fit to eliminate all proposed increases; and

Whereas, this administration will not allocate funds to increase provider fees, which at the present time are far below reasonable reimbursement for services rendered; and

Whereas, federal law indicates that if more than 50 percent of the physicians in any state will not accept Medicaid patients, such state is declared to be in noncompliance and will not receive federal funding; and

Whereas, approximately 10 percent of the physicians in this State care for 90 percent of the Medicaid patient load and the remaining 90 percent of the physicians care for the remaining 10 percent; and

Whereas, if those physicians who see only small numbers of Medicaid patients would decline to accept Medicaid reimbursement on a temporary basis, but yet charitably care for these patients in the highest medical tradition; and

Whereas, by so doing, the physicians who are dependent on Medicaid reimbursement for their livelihood would not be deprived of that livelihood; now therefore be it

RESOLVED, that the Medical Society of New Jersey urge all its member physicians who have only a small percentage of Medicaid patients in their practice to no longer bill Medicaid for these patients, although they should continue to provide care to them in the highest traditions of medical practice; and be it further

RESOLVED, that as a mechanism to accomplish this in a satisfactory and documented fashion, the Medical Society of New Jersey should directly solicit its membership, through first-class mail and pledge cards, to agree to see their Medicaid patients without billing Medicaid for their services, thus putting Medicaid of New Jersey in noncompliance with federal regulations. This procedure of seeing patients but not billing for them would continue until the New Jersey Legislature provides sufficient funds such that Medicaid can reimburse physician providers on a parity with Medicare rates.

Fiscal Note: \$2,300 Estimated

The Reference Committee felt that the report of the Medicaid Committee (page Tr 70) and Resolution #22 interrelate. Joint consideration resulted in the development of Substitute Resolution #22:

Substitute #22

Medicaid Funding and Provider Reimbursement

Whereas, Medicaid of New Jersey recommended an increase of eighteen million dollars in order to reimburse providers in an appropriate fashion and commensurate with increased costs; and

Whereas, this amount was decreased to approximately eight million dollars by the Commissioner of the Department of Human Resources of the State of New Jersey; and

Whereas, the Governor of the State of New Jersey has seen fit to eliminate all proposed increases; and

Whereas, this administration will not allocate funds to increase provider fees, which at the present time are far below reasonable reimbursement for services rendered; and

Whereas, approximately 10% of the physicians in this State care for 90% of the Medicaid patient load and the remaining 90% of the physicians care for the remaining 10%; and

Whereas, Medicaid will reimburse out-patient clinics for the care of Medicaid patients on a cost basis to the provider hospital; and

Whereas, 10% of the members of the Medical Society of New Jersey are having to provide medical services for 90% of Medicaid patients at a fee that is less than their costs for this service; now therefore be it

RESOLVED, that the Medical Society of New Jersey call to the attention of the Governor, the Legislators, the Com-

missioner of Health, and the public thru the news media, the inequity of the payments for the medical services of the Medicaid patients to their own family doctor vs the payment to the hospital out-patient services for this care.

Action from the floor of the House resulted in amendment to the above "Resolved" and the addition of three "Resolveds" to read:

RESOLVED, that the Medical Society of New Jersey call to the attention of the Secretary of Health, Education, and Welfare, the Governor, the Legislators, the Commissioner of Human Resources, and the public through the news media, the resulting discrimination against minority patients and physicians and the inequity of the payments for the medical services of the Medicaid patients to their own family doctor vs. the payment to the hospital out-patient services for this care which are at least 500% greater than the payment for the same services in a doctor's office; and be it further

RESOLVED, that the Medical Society of New Jersey urge all its member physicians who have only a small percentage of Medicaid

patients in their practice no longer to bill Medicaid for services to these patients, although they should continue to provide care to them in the highest traditions of medical practice; and be it further

RESOLVED, that as a mechanism to accomplish this in a satisfactory and documented fashion, the Medical Society of New Jersey should directly solicit its membership, through first-class mail and pledge cards, to agree to see their Medicaid patients without billing Medicaid for their services, thus putting Medicaid of New Jersey in noncompliance with federal regulations. This procedure of seeing patients but not billing for them would continue until the New Jersey Legislature provides sufficient funds so that Medicaid can reimburse physician providers on a parity with Medicare rates; and be it further

RESOLVED, that as soon as a sufficient number of pledge cards are received, the Board of Trustees of the Medical Society of New Jersey, inform the Secretary of the Department of Health, Education, and Welfare, that the State of New Jersey is not in compliance with Medicaid regulations.

Adopted as amended by the House.

REFERENCE COMMITTEE "G"

William E. Ryan, M.D., Mercer

Chairman

Peter A. Beaugard, M.D., Bergen

Howard H. Lehr, M.D., Union

Palma R. Formica, M.D., Middlesex

Edwin W. Messey, M.D., Burlington

Carl A. Restivo, M.D., Hudson

Alternate Member

Reports:

Board of Trustees' Items

Committee on Chronically Ill

and Aging

Council on Public Health and its

Special Committees on:

Cancer Control

Child Health

**Conservation of Hearing and
Speech**

Conservation of Vision

Environmental Health

Maternal and Infant Welfare

Resolutions #15, #16

Board of Trustees' Items

COMMITTEE ON BLOOD PROCUREMENT

(Reference Committee "G")

At the Annual Meeting in May 1977, Reference Committee "G" concluded that the system for blood procurement could be improved upon and recommended an on-going Committee on Blood Procurement.

Suggestions were solicited from appropriate organizations as to how this Committee could be of help in an attempt to identify areas where improvement is needed.

A meeting of the Committee is planned to discuss whether MSNJ can lend advice, support, and prestige in regard to blood procurement more effectively and more efficiently through the present liaison between MSNJ and the New Jersey Blood Bank Association.

Filed in accordance with the recommendation of the Reference Committee.

STUDY OF IMMUNIZATION LIABILITY DIFFICULTIES

(Reference Committee "G")

The Board voted to support a study by the American Arbitration Association of the swine flu liability experience.

The objective is to analyze the claims data and the administrative activity. The study will help to determine whether the present liability program has served its purpose and thus provide a basis for an appropriate system to protect all participants in vaccination programs.

As a condition of supporting this project, the Board will be kept informed as to progress being made and will receive a copy of the finished project.

Filed in accordance with the recommendation of the Reference Committee.

Chronically Ill and Aging

Matthew E. Boylan, M.D., Chairman, Avon By The Sea

(Reference Committee "G")

There being no referrals from the Board of Trustees or other Councils or Committees of the Society, and no requests for action on any projects, there were no meetings of the Committee.

Due to inactivity and lack of interest it is recommended that the Committee on the Chronically Ill and Aging be dissolved.

Any matters relevant to this topic can be referred to the Council on Public Health with the members of this Committee available to assist as consultants.

The recommendation was rejected — Reference Committee felt that with the advent of hospices and similar facilities consideration be given to continuation of this or a similar committee.

Filed in accordance with the recommendation of the Reference Committee.

Public Health

John J. Pastore, M.D., Chairman, Vineland

(Reference Committee "G")

The Council on Public Health met to review all the reports submitted by its various subcommittees. The Council discussed a request from the Center for Disease Control (CDC) soliciting suggestions on future direction of the activi-

ties of the Center. The Council agreed that there should be better communication between the CDC and the private physician. It also was suggested that the CDC become more involved in the research of chronic noninfectious diseases and

epidemiology, beyond their work in immunization programs.

A letter from James H. Sammons, M.D., Executive Vice President of the AMA, dated October 21, 1977, regarding a national immunization initiative launched by the Federal Government was discussed extensively by the Council. It was pointed out that there is a real need for a standard immunization record that would be maintained and trans-

ferred throughout life for every individual. Also it was felt that many private practitioners fail to remind parents when follow-up immunizations are due for their children, and it was suggested that follow up in the primary immunization series be required.

Filed in accordance with the recommendation of the Reference Committee.

Cancer Control

Roy T. Forsberg, M.D., Chairman, Elizabeth

(Reference Committee "G")

The year 1977 was one which met with little success and much frustration.

On the positive side, the chairman represented the Medical Society of New Jersey as Governor Byrne signed a bill mandating cancer as a reportable disease.

He also was the liaison for the Medical Society of New Jersey to the Governor's Committee on Cancer. We met with great hope that something concrete was now to be done, particularly in identifying industrial carcinogens. However, it seems that the Governor was thinking wishfully and in hope of obtaining Federal funds. These were not forth-

coming, so nothing has been heard from the Governor's office since the original meeting.

We did oppose, unsuccessfully, the legalizing of a non-approved cancer drug—laetrile. The Governor and the legislators enacted the legislation permitting use of this worthless material. Evidently they know more than the physicians responsible for care of the cancer patient. Such acts by the administration produce a feeling of frustration and dismay within the medical profession.

Filed in accordance with the recommendation of the Reference Committee.

Child Health

Glenn P. Lambert, M.D., Chairman, Flemington

(Reference Committee "G")

The reorganization meeting of the Special Committee on Child Health was held on February 15, 1978 at which time the Committee discussed activities its Chairman or members have been involved in with the State Department of Education regarding the health and nutrition program, as well as health education curriculum guidelines review.

The Committee indicated its support of the Statewide Immunization Action Campaign being conducted by the MSNJ Auxiliary and the New Jersey League of Nursing. It recommends to the Council on Public Health the universal adoption of the standard school-immunization record of the VA15 form of the New Jersey State Department of Health. The Committee would encourage the use of VA15 immunization on all children.

The Committee indicated its desire to continue partici-

pating in a medical advisory capacity with the Department of Education's Council for Handicapped Children because of the importance of maintaining contact with them on this matter of importance.

The Committee also was concerned about the lack of participation by its members and shall seek means of enlarging its active participants through contact with the component societies in an effort to enlist new active members.

The Committee considered the request of the Council on Public Health with reference to the school health services' procedure of testing and controlling tuberculosis. The problems related to the special needs in Newark led to the Committee making a recommendation for Public Health Council action.

Filed in accordance with the recommendation of the Reference Committee.

Conservation of Hearing and Speech

Aris M. Sophocles, M.D., Chairman, Trenton

(Reference Committee "G")

The Committee has met during the year 1977-78 further to pursue its objectives in hearing and speech. Discussions on screening of hearing in public schools have confirmed the need for such testing and the need to accomplish this through legislation.

An appropriate bill will be resubmitted since S-851 did not

receive the necessary support by its sponsor, Senator McGahn.

Filed in accordance with the recommendation of the Reference Committee, which noted that the unduly brief report reflects a committee which is not active and does not have proper attendance to conduct its business.

Conservation of Vision

Samual B. Pole, III, M.D., Chairman, Bridgeton

(Reference Committee "G")

The 21st Annual Eye Health Screening Program was held during the week of September 25, 1977. A total of 95 hospital centers participated in the program. The number of patients screened was 13,242, of which 6,167 had a positive test finding. The testing included visual impairment, ophthalmoscopy, external conditions, and tonometry.

Of those screened, 750 had positive tonometry tests. The New Jersey State Commission for the Blind and Visually

Impaired will follow up these cases and report back to the Committee.

Since its inception, this program has screened 201,260 patients. The results are being publicized in preparation for the next Eye Health Screening Program which will be conducted during the week of September 24, 1978.

Filed in accordance with the recommendation of the Reference Committee.

Environmental Health

Richard H. Musgnug, M.D., Chairman, Cherry Hill

(Reference Committee "G")

The committee has been involved in trying to raise the Medical Society's awareness of the environmental cancer hazards in our state. Primarily through the work of Doctor Seymour Charles, a panel of experts in the field of environmental health hazards has been brought together to present a program at the Governor's Conference of our annual meeting in May, 1978.

Two resolutions adopted by the 1977 House of Delegates were referred to this committee for our response (Resolutions 26 and 27). Resolution 26 resolved that the Medical Society of New Jersey assay the problem of air pollution in the state and take all effective measures to familiarize the public with the implications of same. It was further suggested that we define and implement corrective measures. Resolution 27, addressing itself to sludge pollution of the coastal waters, resolved that the Medical Society of New Jersey should "initiate action" against this public health problem and work toward legislation or regulations which would move the present twelve-mile dumping sites to 106 miles offshore until 1981, at which time all ocean dumping would be phased out.

In response to the first resolution regarding air pollution, we wrote to Mr. Wortreich, Bureau Chief of Air Pollution Control, in the State Environmental Protection Agency (DEP). We asked him to assay specifically for us: (1) the quantity and geographic distribution of the most significant atmospheric pollutants in the state, (2) the major source of each pollutant and what measures are currently being used to reduce these pollutants, (3) how effective are these measures, (4) what plans does the Department of Environmental Protection (DEP) have for future programs, and (5) what he felt that the Medical Society, either as a whole, in committee, or individually, could do to help him in his fight against air pollution.

Mr. Wortreich's reply was a very complete and well documented letter including eighty pages of air quality regulation plus ninety tables and graphs. We have these on file for anyone who wishes to see them. He felt we could help his fight for cleaner air by: (1) the establishment of a Health Effects Advisory Panel to assist the Clean Air Coun-

cil, (2) providing input regarding priorities in setting ambient air quality standards and in evaluating their results medically so that the standards would, in fact, have an effect on public health, and (3) establishment of a board of medical experts who could testify to specific cases when exposure to a pollutant has produced a medical problem. He feels that in the past they have not gotten the medical support they needed in these areas to act against the polluter.

With respect to resolution 27 and sludge dumping, although we were in complete agreement with the spirit of the resolution and all its clauses, we felt very limited as a committee to be able to respond to the resolution's call to initiate action against the public health problem of pollution of New Jersey waters. For the record, we have on file the DEP's commentary on "Ocean Disposal of Wastes off New Jersey," January, 1974, the DEP report on the fish kill off the New Jersey Coast, August, 1976, and the testimony of Doctor Glenn Paulson, Assistant Commissioner of the DEP, on the location of ocean dumping sites, May, 1977.

In summary, the DEP would like to see ocean dumping stopped and every effort is being made to get municipal sewage authorities to develop safe, planned disposal methods, primarily in the form of composting. If no progress is made with these programs, their next step would be to suggest moving the ocean dump site to 106 miles offshore.

RECOMMENDATION

That the Medical Society appoint a blue-ribbon panel of physicians with expertise and interest in the health-related problems of air pollution to: (1) assist the Clean Air Council in evaluating the health effects of air pollution, (2) assist the DEP in evaluating the public health effects of air pollution control regulations and programs, and (3) be available to give expert medical testimony regarding the health effects of specific pollutants in cases where the DEP may need medical testimony in a chain of evidence to prosecute a polluter.

Recommendation approved in accordance with the recommendation of the Reference Committee.

Report filed with commendation.

Maternal and Infant Welfare

Peter A. Beaugard, M.D., Chairman, Teaneck

(Reference Committee "G")

The Committee on Maternal and Infant Welfare met on October 12, 1977, November 30, 1977, January 15, 1978 and January 26, 1978.

The first meeting, October 12, 1977, was devoted almost entirely to reorganization of the old Maternal and Infant Welfare Committee along guidelines suggested by the AMA, Committee on Maternal and Child Health. Subcommittees to address the following problems were formed:

1. High-Risk Pregnancy—John T. Harrigan, M.D., Chairman
2. Medical Education—Caterina A. Gregori, M.D., Chairman
3. Teenage Pregnancy—Howard Jacobson, M.D., Chairman
4. Maternal Mortality—James P. Thompson, M.D., Chairman

In September, the Board of Trustees referred to the Committee the problem of evaluating guidelines for the function and licensing of nurse-midwives, and requested advice on the matter. This subject occupied many hours of discussion at all our meetings, and an opinion was rendered to the Board of Trustees following our January 26, 1978 meeting. Because of some very sharp differences of opinion on this subject, a majority report and minority report were submitted to the Board.

The Committee recognized that the functions of all those outside medicine who cooperate in delivering medical care (midwives, nurse practioners, physicians' assistants, and

so on) present many common problems and that perhaps none of these groups should be addressed individually. It might be wise for the Board of Trustees to develop a policy applicable to all categories of those who deliver auxiliary services, thus hopefully avoiding conflicts in the future.

In response to the request of the President of the Board of Medical Examiners (who attended the meeting of Reference Committee "G") for guidance (by May 10) in that Boards' decision on the "Proposed Rules on Principal Midwife," the Reference Committee recommended that the matter be referred immediately to the Committee on Maternal and Infant Welfare for action and that the Committee make its findings known directly to the State Board of Medical Examiners.

The Reference Committee recommendation was not adopted.

By action of the House the following conclusions on the issue of nurse-midwives were accepted:

1. No need has been demonstrated for nurse-midwives, even within inner cities.
2. The Proposed Rules on Principal Midwife are so restrictive as to eliminate any meaningful function for nurse-midwives.
3. The rule states that anesthesia shall be administered only by a licensed physician and this leaves in limbo the ability of nurse anesthetists to function with the pregnant patient.
4. If a physician needs to be present during episiotomy laceration repairs, what need is the nurse-midwife?
5. Obstetrical nurses already fulfill most of the functions left to the nurse-midwife.

Report as a whole filed.

Resolutions

#15 Separate Facilities for Nonsmokers

From Gertrude Oberlander Ash, M.D., Delegate, Essex County

(Reference Committee "G")

Whereas, the connection of cigarette smoke and lung cancer is well established; and

Whereas, New Jersey is infamous as the State with the highest incidence of cancer; and

Whereas, New York State has ruled that public restaurants should have separate rooms for smokers and nonsmokers; and

Whereas, the inhalation of smoke by nonsmokers is proved injurious to health and surely disagreeable to them; now therefore be it

RESOLVED, that the Medical Society of New Jersey petition the New Jersey Department of Health to mandate that "no smoking" signs be displayed in all public places such as banks, department stores, post offices, etc.; and be it further

RESOLVED, that the Medical Society of New Jersey petition the New Jersey Department of Health to mandate that all New Jersey eating places open to the public provide separate sections, and where feasible, separate rooms for smokers and nonsmokers.

Reference Committee recommended that the following Substitute Resolution #15, offered by the sponsor, be adopted:

Substitute #15

Separate Facilities for Nonsmokers

From Gertrude Oberlander Ash, M.D., Delegate, Essex County

(Reference Committee "G")

Whereas, the connection of cigarette smoke and lung cancer is well established; and

Whereas, New Jersey is infamous as the State with one of the highest incidence of cancer; and

Whereas, New York City has ruled that public restaurants should have separate rooms for smokers and nonsmokers; and

Whereas, the inhalation of smoke by nonsmokers *may be* injurious to health and surely disagreeable to them; now therefore be it

RESOLVED, that the Medical Society of New Jersey petition the New Jersey Department of Health to *encourage* that "no smoking" signs be displayed in all public places such as banks, department stores, post offices, etc.; and be it further

RESOLVED, that the Medical Society of New Jersey *work with* the New Jersey Department of Health to *encourage* that all New Jersey eating places open to the public provide separate sections, and where feasible, separate rooms for smokers and nonsmokers.

Amended by the House by deleting the word "encourage" in each of the "Resolveds" and inserting the word "recommend" and by deleting the words "post offices" in the first "resolved" to read:

RESOLVED, that the Medical Society of New Jersey petition the New Jersey Department of Health to recommend that "no smoking" signs be displayed in all public places such as banks, department stores, etc.; and be it further

RESOLVED, that the Medical Society of New Jersey work with the New Jersey Department of Health to recommend that all New Jersey eating places open to the public provide separate sections, and where feasible, separate rooms for smokers and nonsmokers.

Substitute Resolution #15 adopted as amended by the House.

#16

Smoking

From the Middlesex County Medical Society

(Reference Committee "G")

Whereas, the Secretary of Health, Education, and Welfare has launched a massive, but partial attack against smoking; and

Whereas, the harm done to personal health by smoking has been documented beyond dispute; now therefore be it

RESOLVED, that the Medical Society of New Jersey applaud the efforts of the Secretary of HEW in this regard; and be it further

RESOLVED, that advertising for all smoking products be banned in all media; and be it further

RESOLVED, that federal subsidies to the tobacco industry be halted and this money be used for an appropriate time to

develop alternate farm crops; and be it further

The Reference Committee recommended that the second and third "Resolveds" be amended to read:

"RESOLVED, that the Medical Society of New Jersey abhors the advertising of all smoking products and recommends that such advertising be banned in all media; and be it further

"RESOLVED, that the Medical Society of New Jersey abhors the federal subsidies to the tobacco industry and recommends that the subsidies be halted and this money be used for an appropriate time to develop alternate farm crops; and be it further"

RESOLVED, that the AMA use all appropriate measures to accomplish these purposes.

Adopted as amended by the Reference Committee.

REFERENCE COMMITTEE "H"

James H. Spillane, M.D., Warren
Chairman
Harry W. Fullerton, M.D., Salem
Edward M. Coe, M.D., Union
Leticia de Castro, M.D., Middlesex
Antonio B. Abad, M.D., Bergen
Paul J. Hirsch, M.D., Somerset
Alternate Member

Reports:
Board of Trustees' Item
Committee on Annual Meeting
MSNJ Auxiliary Advisory Committee
Nominations for Emeritus Membership
Resolution #17, #18

Board of Trustees' Item

NEW SCIENTIFIC SECTIONS **(Reference Committee "H")**

At the request of the individual specialty societies, the Board agreed to establish a Scientific Section on Oncology and a Scientific Section on Nuclear Medicine.

Filed in accordance with the recommendation of the Reference Committee.

Annual Meeting

James E. D. Gardam, M.D., Chairman, Millville

(Reference Committee "H")

For the past several years the Committee has been faced with constructing a satisfactory legislative and scientific annual meeting of our society on the shifting economic, political, and social sands of Atlantic City.

The 1978 meeting has been moved to a new site consisting of the combined resources of the Holiday Inn and The Howard Johnson Hotel. This move was required by the structural changes in Haddon Hall as it prepared for casino operation. The local government, Convention Bureau, Haddon Hall, and Holiday Inn and Howard Johnson managements have provided the utmost cooperation, assistance, and diligence in arranging for the site of our 1978 meeting.

An increase in the number of scientific sessions, the amount of legislative consideration, the impact of special interest concerns—all have resulted in an expanded program for our membership. The Governor's Conference topic is "Identification and Prevention of Environmentally Related Cancer—Is New Jersey #1 in Cancer?" thus meeting the concerns of physicians to obtain experience beyond direct patient care. Besides the well-received Governor's Conference, the additions of the reporting session of AMA Dele-

gates, the JEMPAC functions, the Prayer Breakfast, the inclusion of speakers on special topics, both of scientific and general interest, and the addresses of national officers have provided full programs.

Recognizing these and other factors, the Board of Trustees has instructed the Committee to develop long-range plans for future meetings in regard to site and format. The Committee is continuing to meet and anticipates a full and final report prior to the 1979 meeting with interim reports to the Board as developments occur.

The scientific sessions have combined their efforts this year to plan and present outstanding symposia with full post-graduate credit.

After presentation of all the facts concerning the total absence of convention space and housing for the 1979 meeting, the Executive Committee of the Board instructed the Committee to reserve space for the 1979 meeting at Cherry Hill. There is no other alternative. It is the hope of the Committee that a return to Atlantic City may be accomplished for the 1980 annual meeting.

Filed in accordance with the recommendation of the Reference Committee.

MSNJ Auxiliary Advisory

William J. Roe, M.D., Chairman, Englewood

(Reference Committee "H")

At its July 1977 meeting, the Board of Trustees approved the proposed program of the Medical Society of New Jersey Auxiliary for 1977-78 as submitted. There was no need for a formal meeting of this Committee during the course of the administrative year.

Administrative routine duties as outlined in the Bylaws of the Medical Society of New Jersey Auxiliary were accomplished. Full minutes are preserved in the archives. Actions felt to be significant or of a general interest are as follows:

(1) Priorities included emphasis on membership, legislation, communications, community and family health which included cardiopulmonary resuscitation training for a member in every family, and working with the AMA on immunization awareness.

(2) Adopted the recommendation of the Medical Society's Committee on Medical Student Loan Fund to make this Fund a priority project for 1977-78. Through the untiring efforts of the Auxiliary's Medical Student Loan Fund Chairman and the county auxiliaries, a substantial contribution has been made to the Medical Student Loan

Fund.

(3) Cosponsored the state-wide eye health screening program.

(4) Conducted a Fall Workshop consisting of roundtable discussions covering priority projects. Dr. Frank Watson, chairman of JEMPAC, brought the members up to date on JEMPAC activities and Mr. Vincent Maressa, Executive Director of the Medical Society, spoke on "Current MSNJ Activities."

(5) Legsline program continued. Participated in the following workshops held in Chicago: AMA Education and Research Foundation, Project Bank (covering all auxiliary projects), and Membership.

(6) Maintained liaison with the Medical Society's own Medical Student Loan Fund, Council on Legislation, JEMPAC, the College of Medicine and Dentistry, Committee on Emergency Medical Care concerning CPR, and the Committee on Child Health concerning immunization.

Filed in accordance with the recommendation of the Reference Committee.

Nominations for Emeritus Membership

(Reference Committee "H")

The following nominations for election to emeritus membership at the 1978 Annual Meeting have been received from the component societies. Conforming to the provisions of the Bylaws, Chapter I—Membership, Section 1—Composition (e), all nominees have been members in good standing of a component society and who by reason of age or infirmity have retired from the active practice of medicine; or members of this Society who have been disabled by reason of military service.

Atlantic County

Albert J. Battaglia, M.D., Ventnor City; Age 59
Walter L. Eckert, M.D., Los Angeles, Ca (formerly Somers Point); Age 72
Harry S. Hoffman, M.D., Ventnor City; Age 69
Ronald C. Moore, M.D., Hammonton; Age 81
Allan Rieck, M.D., Pleasantville; Age 80
Louis Rosenberg, M.D., Margate City; Age 74
Lawrence A. Wilson, M.D., Absecon; Age 82

Burlington County

Charles Catanzaro, M.D., Moorestown; Age 58
Harry P. Landis, Jr., M.D., Palmyra; Age 69
William F. Lucas, M.D., Burlington; Age 74
Albert Oppenheimer, M.D., Moorestown; Age 78
Abraham B. Sand, M.D., Burlington; Age 70

Camden County

Raymond A. Davis, M.D., Stuart, Fl (formerly Camden); Age 65

Cape May County

Louis E. Bernheisel, M.D., Tuckahoe; Age 78
Joseph C. Cobots, Cape May; Age 71

Essex County

Richard A. P. Cupaiuoli, M.D., Lakehurst (formerly Maplewood); Age 70
Saul I. Firtel, M.D., South Orange; Age 61
Leonard Gilman, M.D., Essex Fells; Age 65
Edward G. Howe, M.D., New Vernon; Age 60
Henry L. Kaplan, M.D., Livingston; Age 69
Abraham Leff, M.D., Union; Age 71
George A. Maggio, M.D., Hackettstown; Age 70
Zelda I. Marks, M.D., Maplewood; Age 70
Joseph A. Miller, M.D., Barnegat; Age 78
Louis Piloni, M.D., Mantoloking; Age 71
Warren I. Reinhardt, M.D., Riviera Beach, Fl (formerly E. Orange); Age 68
Kenneth F. Schaefer, M.D., Denver, Co (formerly Newark); Age 62
William S. Schram, M.D., Westfield; Age 69
Frank A. Vallario, M.D., Glen Ridge; Age 67
Coler Zimmerman, M.D., West Orange; Age 70

Gloucester County

Harry B. Lockhead, M.D., Glenside, Pa (formerly Woodbury); Age 70

Middlesex County

Benjamin F. Slobodien, M.D., Perth Amboy; Age 86
Sidney Tucker, M.D., Long Branch; Age 68
Mathilda R. Vaschak, M.D., North Plainfield; Age 68
Walter Zarski, M.D., South River; Age 60

Monmouth County

Frank A. Miele, M.D., Keansburg; Age 68

Morris County

Frank D. Fenimore, M.D., Morris Plains; Age 68

Ocean County

E. Charlotte Seasingood, M.D., Island Heights; Age 74

Passaic County

Siegbert Bornstein, M.D., Pomptom Lakes; Age 75
Mario D. Capio, M.D., Paterson; Age 64
S. Bell Lucent, M.D., Little Falls; Age 82

George L. McCarthy, M.D., Paterson; Age 75
Ann Moyes, M.D., Kinnelon; Age 67
Abraham Shechtman, M.D., Plantation, Fl (formerly Passaic); Age 68
Harry Wolfson, M.D., Paterson; Age 77

Somerset County

William F. Jones, M.D., Winston Salem, NC (formerly Somerville); Age 64
Gene Rossi, M.D., Bound Brook; Age 66

Sussex County

Edward C. Thompson, M.D., Sussex; Age 64

Union County

Anthony E. Abramo, M.D., Short Hills; Age 65
John J. Blumberg, M.D., Solana Beach, Ca (formerly Elizabeth); Age 57
Stanley J. Fink, M.D., Roselle; Age 65
Max Shapiro, M.D., Elizabeth; Age 67
Herbert Weltchek, M.D., Elizabeth; Age 63

Approved in accordance with the recommendation of the Reference Committee.

Supplemental Report #1

The following additional nominations for election to emeritus membership have been received:

Hudson County

John S. Bogacz, M.D., Jersey City; Age 70
Daniel S. Cieri, M.D., Union City; Age 70
Robert A. Cosgrove, M.D., Sea Girt; Age 67
Sidney Katz, M.D., Longboar Key, Fl (formerly North Bergen); Age 61

Warren County

John F. Burke, M.D., Phillipsburg; Age 59

Approved in accordance with the recommendation of the Reference Committee.

Supplemental Report #2

The following additional nominations for election to emeritus membership have been received:

Camden County

Joseph Newmeyer, M.D., Cherry Hill; Age 66

Essex County

Joseph I. Echikson, M.D., Maplewood; Age 80

Louis Grunt, M.D., Union; Age 70
Aaron Lowenstein, M.D., Orange; Age 75

Approved in accordance with the recommendation of the Reference Committee.

Resolutions

#17 Annual Meeting in Atlantic City

From the Bergen County Medical Society
(Reference Committee "H")

Whereas, for many years the Medical Society of New Jersey has traditionally held its Annual Meeting in Atlantic City; and

Whereas, Atlantic City has many attractions which draw the families of the physicians; and

Whereas, the other sites available for holding the Annual Meeting are somewhat lacking in complete facilities for serving the interests and comforts of New Jersey physicians and their families; now therefore be it

RESOLVED, that the Bergen County Medical Society urges the Medical Society of New Jersey to make every effort possible to hold the Annual Meeting in 1979 in Atlantic City.

Rejected in accordance with the recommendation of the Reference Committee

Substitute Resolution #17 (see below) was offered from the floor by the original sponsor.

Substitute #17 Annual Meeting in Atlantic City

Whereas, it is apparent that facilities in Atlantic City will not be available for the Annual Meeting until 1980 or later; and

Whereas, many of the delegates have voiced disfavor and disappointment with Cherry Hill because of past dissatisfactions; now therefore be it

RESOLVED, that the Medical Society of New Jersey Board of Trustees strongly consider holding the Annual Meeting in 1979 in either Philadelphia or New York City.

Rejected by the House.

#18 MSNJ Convention Entertainment

From Essex County Medical Society
(Reference Committee "H")

Whereas, there are many excellent entertainment packages available to convention programmers; and

Whereas, the attendees at our conventions should have a change in entertainment at dinners and other Annual Meeting functions to relax from their routine duties; and

Whereas, a varied program with new faces and acts is desirable to those who attend all our functions; and

Whereas, repeat performances could discourage support of our social functions; now therefore be it

RESOLVED, that the Committee on Annual Meeting of the Medical Society of New Jersey be instructed to seek new entertainers and acts annually.

Rejected in accordance with the recommendation of the Reference Committee.

The House concurred in the decision of the Committee on Resolutions that Resolutions #19 and #21 were not acceptable as emergency resolutions.

The following resolution was presented from the floor under New Business:

#23

Reimbursement of President and Chairman of the Board

From Barbara A. Mazzela, M.D., Delegate, Bergen County

Whereas, the Society, most of the time, has chosen to elect a physician in the active practice of medicine to the post of Second Vice-President, expecting that he or she will eventually be their President; and

Whereas, if this philosophy is to continue, then the Society should make it financially possible for the President to make it a full-time position for his year in office; and

Whereas, the Society should assist physicians who may not have large personal assets in becoming officers; and

Whereas, the present stipend to the President of the Medical Society of New Jersey is only \$15,000 and no stipend for the Chairman of the Board; now therefore be it

RESOLVED, that the President of the Medical Society of New Jersey's stipend be increased to \$75,000 a year for the year he or she is in office and \$25,000 for the first year out of office; and be it further

RESOLVED, that the Chairman of the Board of Trustees of the Medical Society of New Jersey be given an annual stipend of \$25,000; and be it further

RESOLVED, that these stipends are to help defray the physicians' loss of income during his or her tenure.

The House of Delegates referred Resolution #23 to the Board of Trustees, without comment.

Report of the Nominating Committee and Election

John S. Madara, M.D., Chairman

Office	Term	Nominee and County
President-Elect	1 year	Alfred A. Alessi, M.D., Bergen
1st Vice-President	1 year	George L. Benz, M.D., Essex
2nd Vice-President	1 year	Augustus L. Baker, Jr., M.D., Morris
Trustees:		
^a 1st District	1 year	Myles C. Morrison, Jr., M.D., Morris
1st District	3 years	Alexander Kovacs, M.D., Union
1st District	3 years	William Greifinger, M.D., Essex
2nd District	3 years	John J. Crosby, M.D., Hudson
2nd District	3 years	Richard E. Lang, M.D., Passaic
3rd District	3 years	Frank Campo, M.D., Mercer
3rd District	3 years	Howard D. Slobodien, M.D., Middlesex
4th District	3 years	John P. Kengeter, M.D., Ocean
Judicial Councilors:		
1st District	3 years	Merton L. Griswold, M.D., Union
4th District	3 years	Frederick W. Durham, M.D., Camden
AMA Delegates:		
	2 years	George L. Benz, M.D., Essex
	2 years	Karl T. Franzoni, M.D., Mercer
	2 years	Frederick W. Durham, M.D., Camden
	2 years	Henry J. Mineur, M.D., Union
	2 years	Robert E. Verdon, M.D., Bergen
AMA Alternate Delegates:		
	^b 1 year	Frank Y. Watson, M.D., Essex
	2 years	John S. Madara, M.D., Salem
	2 years	Myles Morrison, Jr., M.D., Morris
	^c 2 years	Palma Formica, M.D., Middlesex
Delegates and Alternate Delegates to Other States:		
New York:		
Delegate	1 year	Albert F. Moriconi, M.D., Mercer
Alternate	1 year	F. Sterling Brown, M.D., Atlantic
Connecticut:		
Delegate	1 year	Edward M. Coe, M.D., Union
Alternate	1 year	Gastone A. Milano, M.D., Atlantic
Administrative Councils:		
Legislation:		
5th District	3 years	Samuel B. Pole, III, M.D., Cumberland
6th Member	3 years	Peter A. Beaugard, M.D., Bergen
Medical Services:		
5th District	3 years	Armando F. Goracci, M.D., Gloucester
6th Member	3 years	Frank Wolf, M.D., Warren
Mental Health:		
^d 3rd District	3 years	Joseph J. Kline, M.D., Mercer
6th Member	3 years	Joseph P. Cillo, M.D., Union
Public Health:		
5th District	3 years	Samuel Ingraham, II, M.D., Cape May
6th Member	3 years	Patrick J. McGovern, M.D., Hudson
Public Relations:		
2nd District	3 years	Frank R. Begen, M.D., Bergen
5th District	3 years	Gastone A. Milano, M.D., Atlantic
Standing Committees:		
Annual Meeting	3 years	Arthur C. Dietrick, M.D., Burlington
Finance and Budget	3 years	Harry M. Carnes, M.D., Camden
Medical Defense		
and Insurance	3 years	E. Arthur Kratzman, M.D., Union
Medical Education	3 years	Edwin W. Messey, M.D., Burlington
Publication	3 years	John F. Marshall, M.D., Mercer
Auxiliary Advisory	3 years	J. James Pegues, M.D., Burlington

^aElected to fill the unexpired term of Augustus L. Baker, Jr., M.D., who was elected Second Vice-President.

^bElected to fill the unexpired term of Frederick W. Durham, M.D., who was elected an AMA Delegate.

^cNominated from the floor and elected by the House in place of the Committee's nomination.

^dMartin H. Weinberg, M.D., who had been named by the Nominating Committee was ineligible by reason of having served three consecutive terms. The Board of Trustees selected Dr. Kline to fill the vacancy.

ATTENDANCE

County	Delegates	Members	Total
Atlantic	10	50	60
Bergen	40	30	70
Burlington	12	41	53
Camden	24	45	69
Cape May	3	6	9
Cumberland	6	6	12
Essex	69	78	147
Gloucester	5	7	12
Hudson	24	29	53
Hunterdon	3	1	4
Mercer	25	40	65
Middlesex	24	22	46
Monmouth	22	31	53
Morris	20	21	41
Ocean	9	14	23
Passaic	27	21	48
Salem	3	7	10
Somerset	7	20	27
Sussex	3	3	6
Union	32	46	78
Warren	3	2	5
Fellows and Officers	23	—	23
	394	520	914
Physician Guests			48
TOTAL PHYSICIAN REGISTRATION			962
Auxiliary			290
Visitors			388
TOTAL REGISTRATION			1,640

FIVE-YEAR COMPARATIVE REGISTRATION FIGURES

Year	Physicians	Others	Total
1978	962	678	1,640
1977	1,115	1,125	2,240
1976	1,147	801	1,948
1975	1,363	1,079	2,442
1974	1,051	1,024	2,075



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